A. And also, as a comparison paper, that we had approximately the same number of cases and we just did not have the complications that they had had.

Q. And is your view based on anything else other than what you have just mentioned?

A. Well, that is only one piece of it. There is a body of evidence that says that D&Es have a lower complication rate than inductions, and that goes back some 20 years over a long period of time comparing different modalities of second trimester terminations.

Q. And are you referring to at any particular gestational age when you are referring to the body of evidence showing D&Es with a lower complication rate than induction?

A. The majority of the information is through approximately 19 weeks. We have not had a lot of objective data looking at induction versus D&Es between 19 and 23 weeks, and there are several [86] papers out there that basically do a disclaimer that because of lack of numbers, they really can't make an adequate comparison.

Our paper is certainly not perfect and we have some flaws in what we came up with, as well, that limits what we can say about it, but we did have a much—we didn't have a higher risk of uterine perforation or complications after cesarean section with D&Es, where they did. And, number two, we had a lower overall complication rate, and that is indirect evidence that D&E through 23 plus weeks is safer than induction.

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[97]

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Q. And when you—and in talking just now about D&E versus induction at 13 to 23 weeks, are you including in that—in your definition or in your reference to D&E, intact D&X, as referred to [98] in the ACOG paper?

A. It would be hard to differentiate a D&E from a D&X on the basis of the statistics that are compiled on a yearly basis by the CDC and as well as the Guttmacher Institute because I do not think that either agency classifies D&X as to the procedures. I don't know, but I think that is the case.

And over a long period of time, the statistics on D&E have been shown to be safer. I have included that from the CDC statistics in my medical student lecture, and so I don't think that D&X really falls in that bailiwick, but I can't tell you that none of the D&Es might have been a D&X.

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[107]

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Q. Is there any added risk to the mother in doing an intracardiac KCl injection in conjunction with your induction procedures?

A. In certain circumstances, yes, it is.

Q. In what circumstances?

A. If you are dealing with a patient who has an intrauterine infection. You are putting her at increased risk. If you are dealing with a very obese patient, you may not be able to do it.

You—it is an additional risk. It is a needle going into the uterus and, as such, even with very careful ultrasound guidance, you may not achieve it. You may not be able to do it, especially if [108] you have low amniotic fluid volumes.

Q. What is the increased risk or likelihood of infection in doing a KCl injection? Can you assign a number?

A. Well, I can't because I really don't have any way to assign a number. It is a transabdominal technique, and you are going into the uterus. Now, if there is infection in the uterus, then you have the likelihood of seeding the abdominal cavity as well as the subcutaneous area of the mother. Likewise, you also have the ability to pick up bugs from surfaces of the skin, even though you have cleansed the skin prior to doing the procedure and putting bacteria into the uterus.

So, yes, it is an additional risk. I can't give you exactly how much risk. If you think about it analogous to an amniocentesis, infection with amniocentesis happens in about 1 in 1,000 procedures, so that is the only number I can come up with.

Q. How about with an obese patient, is there an increased risk?

A. An obese patient, you have a problem of actually reaching the fetus. You also have a [109] problem of visualizing what you are doing. The adiposity decreases your ability to visualize. It also limits what you actually can do, so it makes it a very technically difficult procedure, one that the patient won't necessarily tolerate well, and it is just—it is an added burden on the patient to do that kind of procedure.

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[115]

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Q. If you have a patient and an induction abortion is started and sepsis ensues, what would you do to complete the termination or what could you do?

A. It really would depend upon the amount of cervical dilatation. Often in those cases you have enough cervical dilatation that you can go in and empty the uterus as a D&E or a D&X, and sometimes the patient has been laboring alone and you actually can get the fetuses out intact.

Q. Continuing the induction or using one of the D&E or D&X?

A. D&X. Because what happens when you have—the real problem with sepsis is, is not only getting the fetus delivered but getting the placenta out. And you can ensure that you can [116] empty that uterus and empty that placenta by doing a D&E in that situation, rather than waiting around with a placenta in place, waiting around with an unstable patient.

It is a very, very bad situation, and we have had two patients in the last year that have fallen into that category, one of which we delivered triplets as intact.

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[161]

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Q. Acute fatty liver of pregnancy, is termination medically indicated in the second trimester in that scenario?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Yes.

BY MS. WOLSTEIN:

Q. Is a particular method indicated?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. It would be safer to do a D&E than it would be to do an induction. Again, we are talking in generalities here.

BY MS. WOLSTEIN:

Q. Why would it be safer to do a D&E?

A. Because you get the procedure over under a defined period of time rather than over a prolonged period where you have to medically manage the patient, as well. Prior to getting the [162] placenta delivered, you are increasing her risks of complications, the longer you keep her pregnant. A similar scenario would be for severe preeclampsia.

Q. In your view, it would be better to do a D&E than an induction?

A. It is always better to do a D&E than an induction.

Q. And in the case of severe preeclampsia, is— either as between a dismemberment D&E and a D&X, is one or the other contraindicated for severe preeclampsia?

MS. CHAITEN: I object to the form.

BY THE WITNESS:

A. No. But you have to remember it is a continuum. When you start a D&E, you can actually be doing a D&X.

BY MS. WOLSTEIN:

Q. With acute fatty liver of pregnancy, is a dismemberment—is either a dismemberment D&E or a D&X superior in that—with that condition?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Actually, an intact D&E would be preferable in this situation because there would be [163] less bony spicules exposed to the cervix and cause cervical lacerations.

BY MS. WOLSTEIN:

Q. And does that relate specifically to something about acute fatty liver of pregnancy, or is that based on your view that it is better to do a D&X because you get fewer bony fragments?

A. Any time you have an increased risk of hemorrhage and a disseminated intravascular coagulation. An acute fatty liver of pregnancy, you can have disseminated intravascular coagulation, so, therefore, you have increased risks of hemorrhage. Therefore, you decrease your risk to the mother if you deliver it as intact as possible.

Q. Does use of instruments in someone who is at risk of hemorrhage pose any added risk to the mother?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. It depends upon what instruments you are talking about. Certainly, if you are talking about a D&E, the more times I have to put my instrument within the uterus to get the fetal parts out, the [164] higher the risk of perforation. That having been said, the more widely dilated the cervix is, the less likelihood I am going to have any problem in delivering the fetus as intact as possible.

BY MS. WOLSTEIN:

Q. Is dismemberment D&E contraindicated in the case of acute fatty liver of pregnancy?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. I think that there is no body of evidence to say that it is contraindicated. It is—it is a preference on the part of the surgeon, and there may be medical conditions such as I have alluded to, including disseminated intravascular coagulation, which can be associated with acute fatty liver of pregnancy which would say that the dismemberment increases the risk to the mother and, therefore, a D&X is preferable.

Q. How about placental hemorrhage, is pregnancy termination medically indicated in those cases?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Placental hemorrhage can be a cause of [165] maternal death. Pregnancy termination is indicated. If you induce a patient with placental hemorrhage or abruption or a chronic abruption, you actually increase

the amount of blood that she can lose during the process of the induction.

So although D&Es are not available in 50 states in the United States, it would be preferable if she had a D&E or a D&X because, actually, if you can get ahold of the fetus, you can use that to tamponade your placental abruption or chronic abruption and deliver the fetus as intact as possible, thereby getting the placenta delivered quickly so thereby you decrease her total blood loss.

Q. And, in your view, is induction contraindicated in a woman with placental hemorrhage?

A. I think so. That is my opinion.

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[171]

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Q. * * * And I think—how about pulmonary hypertension, would that be a condition for which pregnancy termination is indicated?

A. Yes.

Q. Is any particular method—if the woman is in the second trimester, is any particular method indicated?

MS. CHAITEN: Object to form.

BY THE WITNESS:

A. Actually, a D&E would be preferable because labor is not in her best interest. I have another one. Paroxysmal nocturnal hemoglobinuria where prostaglandins are contraindicated.

BY MS. WOLSTEIN:

Q. So you would want to do a D&E in that scenario?

A. Yes.

Q. Or a D&X?

A. Either one.

[172]

MS. CHAITEN: Object to the form.

BY MS. WOLSTEIN:

Q. Would one or the other be preferable based on the mother's condition?

MS. CHAITEN: Objection to form.

BY THE WITNESS:

A. A D&X would be preferable because you have no platelets, as well. You have low hemoglobin.

BY MS. WOLSTEIN:

Q. Because—preferable because it is lower risk of perforation from instruments?

A. Lower risk of blood loss.

Q. So, in your view, D&X poses a lower risk of blood loss than a dismemberment D&E?

A. Yes.

Q. And what is that view based on?

A. It is based on my experience and the fact that bony parts can lacerate the cervix as they are brought through the cervix, and the cervix is one—is something that you can actually nick the branch of the uterine artery at the internal os of the cervix and cause enough bleeding that you have to either do a hypogastric artery ligation or [173] else a uterine artery embolization to stop bleeding.

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[176]

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Q. If you can turn to your expert report, 40-C.

A. What page are you on, please?

Q. I am on—I'm going to ask about page 2.

Well, is it your opinion that a D&X is safer for the mother in a dismemberment D&E at some point in gestation?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Yes.

BY MS. WOLSTEIN:

Q. And what point would that be?

[177]

A. It is throughout the second trimester.

Certainly beyond 17, 18 weeks it is definitely safer.

Q. What is your view that it is safer based on?

A. My experience.

Q. Anything else?

A. No.

Q. What makes, in your view, the D&X safer in D —than dismemberment D&E at 17, 18 weeks and beyond?

A. Dismemberment requires the forceps to go into the uterus multiple times. Whereas, when you are doing an intact D&X, you can get the fetus out as intact as possible. It is safer because there is less instrumentation of the uterus.

Number two, there are less bony parts, and there are bony parts before—beyond 20 weeks and you will get them and they can be very difficult to get them through the cervix without lacerating the cervix.

Another thing is that if you have—you have more ability to—if you get ahold of the fetus and can bring it through the cervix virtually [178] intact, it is a shorter procedure and you can get your placenta out faster and you can end the procedure faster.

Q. Your report also mentioned advantages for testing to ascertain the cause of fetal anomalies as an advantage of D&X?

MS. CHAITEN: Could you show us where you are?

MS. WOLSTEIN: Yes.

BY MS. WOLSTEIN:

Q. I will read the sentence. It is the second to the last sentence, "Finally, an intact fetus offers advantages for testing to ascertain the cause of fetal anomalies, an advantage particularly important in a practice such as mine involving high-risk and very much wanted pregnancies."

A. Fetal anomalies range from Down's, which any lay person is probably familiar with, to body stock anomalies where the fetus is stuck to the placenta and induction is really truly contraindicated.

If you can get the fetus out intact as possible, you can confirm ultrasound findings. We have progressed from the diagnosis of neural tube [179] defects and chromosomal anomalies to being able to pick up subtle changes or subtle differences in dysmorphic

features, not necessarily facial features but that we see in the hands and the feet.

Case in point, I had a patient who was terminating a fetus for bilateral club feet, and the hands, when I got them out intact, showed a fixed contracture, as well. So we were not dealing with just club feet. We were dealing with an arthrogryposis probably on a neuromuscular basis.

Getting the fetus out as intact as possible provides a perinatal pathologist with the best opportunities to help us pin down the anomaly and then help us to counsel the patient about recurrence risk as well as provide a plan of management for prenatal diagnosis, either with the gene, if we have it, or early ultrasound if we have to rely on ultrasound.

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[197]

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Q. Tell me if you agree or disagree with the following statement: "D&X is safer than dismemberment D&E because it reduces the risk of [198] bony fragments lacerating the uterus"?

A. I agree with that.

Q. So you can say with certainty that it is—that D&X is safer than D&E, in that it reduces the risk of bony fragments lacerating the cervix?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Well, in my hands and my experience, getting the fetus out as intact as possible ensures that there are

less bony fragments that may lacerate the cervix, thereby reducing the risk of cervical laceration.

BY MS. WOLSTEIN:

Q. You also mentioned instrumentation, that D&X involves fewer passes of instruments in and out as one reason you consider it safer than dismemberment D&E?

A. Yes.

Q. What is the basis of that view?

A. Experience.

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[202]

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Q. Do forceps pose a risk of laceration to the cervix?

A. In my opinion, they don't.

Q. Does use of a scissors, in a D&X or a D&E, as you have described how you use the scissors, does that pose a risk to the mother?

A. The way I use it, no.

Q. Do you consider a scissors that you use in a D&E or D&X potentially more dangerous to the mother than a forceps, if a mistake is made?

MS. CHAITEN: Object to the form.

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[203]

A. A scissors might be more dangerous, yes.

BY MS. WOLSTEIN:

Q. How so?

A. Because it is a sharper instrument.

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[217]

Q. * * * Is it your view that the literature supports the view that intact—the intact variant of D&E or D&X or intact D&X is safer than induction?

A. There are no statistics comparing that, but doing an intact D&E as a variant of D&E—and the CDC does not separate the two procedures, so it is going to be melded into a D&E, which comprises 99 percent of abortions within the United States right now and that has the lowest complication rate for second trimester terminations for women.

Q. And you are referring to what is referred to in that literature as D&E?

A. The D&E will include the D&Xs on a large population basis, which is, by law, keeping track of abortion mortality and morbidity statistics nationwide. And that is the CDC statistics, and they don't make a distinction.

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695

NATIONAL ABORTION FEDERATION, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS CAPACITY AS
ATTORNEY GENERAL OF THE UNITED STATES,
DEFENDANT

DEPOSITION OF AMOS GRUNEBAUM, M.D.

Feb. 2, 2004

APPEARANCES:

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[8]

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Q. Can you please briefly describe for me your duties as the director of clinical maternal fetal medicine at New York Cornell?

A. My duties include the clinical care for high risk pregnant woman, the teaching of residents and of medical students, and I also have a session in the faculty practice offices at Cornell where I see women in ObGyn, both pregnant and non-pregnant.

I also give lectures and attend conferences, and I perform medical and surgical procedures in the operating rooms at Cornell. I make rounds on patients.

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[47]

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Q. Why don't you read the first sentence out loud of paragraph 9, Doctor.

A. I've participated in and performed approximately 100 D&Es, including intact D&Es over the past three years.

Q. How many of those 100 D&Es were not intact D&Es?

A. About 50 percent, 60 percent, about 50 percent to two-thirds.

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[61]

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Q. I'm sorry. I don't understand that.

[62]

What do you mean the original diagnosis?

A. If they come with a diagnosis of abnormal fetus or chromosomal abnormality, they are able, instead of me just saying, okay, you want it done; let's do it. I can also counsel them at the same time about that issue.

Many of my patients ask me how sure can you be that this was the right diagnosis because that's really important for them. They're also going to ask me, can I hold the baby after I deliver after the procedure. And some of my patients ask me can you try to deliver it intact so I can hold the baby and see the baby. I know that there are malformations. I would like to just reassure myself that I did the procedure for the right reason.

Q. What do you tell them if they ask you that?

A. I tell them I cannot deliver that I can deliver the baby, the fetus, completely, but I will make a safe attempt to do so. And some of them say that they have made arrangements for pathologists to examine the fetus. And if it's done completely, that will help the pathologist to examine the fetus.

I have experienced that patients who are able to hold the fetus after I tell them about [63] this, sometimes they feel better about this and are more likely on a personal bases to accept the procedure.

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[66]

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Is there a difference in your mind in terms of the amount of cervical preparation you perform for those two?

A. I believe I've testified that I don't prepare a patient differently for an intact D&E as compared to the D&E, per se. I prepare all patients for a D&E procedure, and one form of it could be an intact D&E.

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[108]

[GOWAN EXAMINES GRUNEBAUM]

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Q. And at what gestational age is the tissue of a—does the tissue permit the intact extraction, as you described it?

A. It permits it throughout pregnancy, but it's easier after 20 weeks because the fetus is bigger. Before 20 weeks it's less likely to be successful because as you pull on the fetus you are more likely to dismember it.

Q. And that's because of the nature of the tissue?

A. And because it's also smaller, much more fragile.

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[138]

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Q. Let's focus on the operative time which I think you delineate more specifically in paragraph 12 of your report. What's the basis of your statement that intact D&E takes significantly less time than D&E by dismemberment?

A. It's the observation of cases I've seen and cases I've done.

Q. And what have you noticed?

A. I've noticed that if you can do a D&E safely as an intact D&E, the procedure to deliver the fetus is faster than it is with a dismemberment D&E.

Q. How much faster?

A. Significantly faster.

Q. What does that mean?

A. Maybe twice as fast, half as fast.

Q. Give me some minutes, some time. 10 minutes? 20 minutes?

A. Difficult to say. I can't pinpoint it [139] down because if it's difficult to do it with intact D&E, then it will be more difficult to do when it's normal D&E.

Q. What do you mean it's difficult to do?

A. Because the fetus may be too high or you may have difficulty getting the fetus, but I would say in general it's probably twice as fast.

Q. Are you saying that sometimes it might take longer to do the intact D&E because of difficulties you might have with getting the fetus than it would to do the D&E by dismemberment?

A. No, I'm not saying that. I'm saying some intact D&Es take longer or shorter than others.

Q. But your view is they're always faster than D&E by dismemberment?

A. No. They're usually faster.

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[145]

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Q. I would like to focus for a minute on your statement in paragraph 12 that the intact D&E decreases the amount of anesthesia that the woman is exposed to as opposed to D&E by dismemberment. What's the basis for that statement?

A. It's the same as the first sentence. If it decreases the operative time, then it decreases the amount of anesthesia because the woman gets less anesthesia.

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[147]

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Q. What are you referring to in particular?

A. When you use instruments and you enter with the instruments into the uterus, you can injure the uterus and that can lead to blood loss. With the intact D&E your risk of using those instruments and injuring the uterus is significantly less and thus decreases the blood loss.

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[150]

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Q. Paragraph 13, what's the basis for your statement that, quote, intact D&E decreases the risk of injury to the cervex and the body of the uterus, which is one of the known complications of D&E, closed quote?

A. With a dismemberment D&E, we usually use instruments which we push blindly into the [151] uterus, so there is a risk that we can perforate the uterus with those instruments. It's an extremely scary situation, and I don't think any doctor will tell you differently who has done this procedure that it is associated with a potentially complicated outcome.

With an intact D&E, you do not have to take those instruments and blindly put them into the distended uterus and remove fetal parts. So with the dismemberment, the risk is higher. In fact, you do an intact D&E, and the placenta comes spontaneously. The risk of perforating the uterus is as close to zero as you can be because there is no instrument that enters the uterus.

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[159]

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Q. In paragraph 15 of your report you state that having intact D&E available is particularly important for women with certain conditions. Then you say, quote, these include, for example, women with an increased risk of hemorrhage or infection, period, closed quote. What are you referring to there specifically?

A. Women who have blood disorders, for example, who are more likely to bleed. For them the intact D&E is less life-threatening if you can deliver the fetus intact because the risk of injury to the uterus is lessened. And if you do have injury to the uterus in a patient who has a risk of hemorrhage she can bleed to death.

Q. Wouldn't you—well, I should say why if a woman had a blood disorder would you even want to do a D&E procedure at all? Why wouldn't you want to do termination by prostaglandin induction?

A. Because it's the woman's choice and it's her option, and you can offer her. With a [160] prostaglandin induction, as we discussed before, sometimes you're not successful. Sometimes the cervex doesn't open up. It's a long procedure. Some women feel that they do not want to be in the hospital for days at a time.

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Q. You wouldn't suggest that that might be preferable over a D&E procedure or intact D&E procedure where there are some instruments used?

A. If you've ever seen a D&E done by an experienced person, you would never suggest a prostaglandin induction to a woman to stay in the hospital for that long time and to undergo hours and hours of labor.

Q. No matter what the blood disorder?

A. Most experienced doctors with D&E feel very confident to do it in those cases.

Q. Do you put yourself in that group?

A. Soon not anymore because I don't do them anymore.

[161]

Q. Why did you stop?

A. Because of the law, because I heard that I might go to prison, and because I'm not clear on what I can and cannot do, which is very—

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[164]

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Q. And what about infection, what are you referring to there specifically?

A. Suppose I have a woman who comes in with ruptured membranes and she has an infection, she has what's called septic abortion. It's not induced [165] abortion. It's spontaneous abortion, a septic spontaneous abortion. Septic means that she has bacteria in her blood already from the infection in her uterus.

In those cases, the bacteria grow in the fetus, they grow in the placenta and in the uterus and they make the uterus very infectious. The longer you wait, the more of a chance it is that the mother is going to be really sick and, in fact, die. Septic abortion before abortion was legal was the major—one of the major causes of women dying of an effect from abortions.

Q. You wouldn't do an intact D&E in that circumstance because you wouldn't have to wait two days to have her dilate the cervex, would you?

A. Yes, but they can come in—well, no. Just a second. The waiting to dilate the cervex and the intact D&E are two separate things.

Q. But you were just describing a woman coming in to see you and this was her condition.

A. And she's infected.

Q. And if that is her condition, are you then going to take two days to dilate her cervex to do an intact D&E?

A. I examine her. Her cervex is 3 [166] centimeters dilated. The fetus is there with the breech and the fetus is alive. The safest medical procedure for me, as a physician, to do at that moment is to bring her to the operating room and do an intact D&E because if I use instruments in an infected uterus, I make the whole situation much worse and I can kill her.

The safest thing is to bring her to the operating room, to remove the fetus as I would in an intact D&E, every intact D&E, and decrease the amount of time. If the law tells me I cannot do it, I know I have to do D&E and am forced to do, quote, unquote, the other D&E, which is the dismemberment D&E which increases the risk.

So I'm forced as a physician to do a less safe, in my mind, a less safe procedure for the woman. And in my conscious I can't do it.

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[203]

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Q. Do you think there's any risk presented by the internal podalic conversion?

A. In a term pregnancy there is a risk, and I've done those. I've done many of those.

Q. What about at 23 weeks?

A. If you do it carefully and gently and if it can easily be done, there is a slightly increased risk of perforating the uterus.

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Q. What about at 20 weeks?

A. There is slight increased risk.

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[206]

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Q. So are you agreeing with Congress's [207] finding that intact D&E poses a risk of lacerations in secondary hemorrhaging?

A. Yes, I agree with that.

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[211]

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Q. In your opinion is intact D&E ever the only appropriate procedure for terminating a pregnancy?

[212]

A. An intact D&E is rarely, if ever, the only medical procedure. But you can say the same thing for nearly every medical procedure that's being done. There's always an alternative to it.

Q. When you say "rarely," can you give me an example of when you think that it would be the only appropriate procedure for terminating a pregnancy?

MS. PARKER: Objection. Vague. Before, you said the only procedure. Now you said the only appropriate procedure. What's the question here?

Q. Did you understand my question?

A. The only procedure, I cannot think of a circumstance where a D&X is the only procedure available.

Q. Can you identify for me any circumstance in which you believe that D&X would be medically necessary to preserve maternal health?

A. D&X is a part of a D&E procedure. There are circumstances, some of which we discussed today, where D&E is preferable over an induction termination of pregnancy. So when we start doing the D&E, I realize that the fetus is presenting with a [213] breech and the cervex is adequately dilated. At that moment I can choose to either do an extraction D&E or a dismemberment D&E. Those are my choices at that moment.

Q. I understand that those are your choices at the moment, and I understand that you make your choice at that moment. But is it ever in your view medically necessary to pick one over the other for purposes of maternal health?

A. I'm glad you bring up this question. We rarely ever have a single procedure that is absolutely necessary. As a physician, I have to choose which one is a better procedure than the other. We always have to make—every time I'm in the operating room, every time I do delivery, I have to choose which one at that moment is the safest possible procedure.

Are there others? Sure there are others. But in my experience, I'm being asked what do you think is best for the patient at this point.

Q. And those safety advantages are the ones associated with less instrument use, less, as you've told me—

A. Less instrument use. No instrument use, in fact. No use of forceps, I'm sorry. No use [214] of instru-

ments which enter the uterus in order to remove the fetus.

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695

NATIONAL ABORTION FEDERATION, MARK I. EVANS, M.D., CAROLYN WESTHOFF, M.D., M.Sc., CASSING HAMMOND, M.D., MARC HELLER, M.D., TIMOTHY R.B. JOHNSON, M.D., STEPHEN CHASEN, M.D., GERSON WEISS, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, ALONG WITH HIS OFFICERS, AGENTS, SERVANTS, EMPLOYEES, AND SUCCESSORS IN OFFICE, DEFENDANT

DEPOSITION OF
CASSING HAMMOND, M.D.
Feb. 18, 2004

APPEARANCES:

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By: MS. DEBORAH ADLER
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By: MS. SHEILA M. GOWAN
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Appeared on behalf of the Defendant

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[GOWAN EXAMINES HAMMOND]

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Q. Okay. First, what I would like to do is get sort of a general understanding of your medical background, where you trained, where you performed your residency, what your specific certifications are.

A. I went to medical school at the University of Missouri at Kansas City and was [6] enrolled in their six-year BA/MD program.

After completing my training in 1988, I moved to Rochester, New York, where I performed my four-year residency in obstetrics and gynecology.

Following my residency training, I was in private practice in Rochester, affiliated with the University of Rochester for three years.

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Q. And then what did you do after leaving [7] Rochester?

A. I left Rochester in 1995 and returned to academic practice here at Northwestern University.

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Q. Okay. And so you came in 1995 to Northwestern, and in what position?

A. I was an instructor in the Department of Obstetrics and Gynecology and a member of the Division of General Obstetrics and Gynecology.

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Your CV—it is not a test. And what's on our CV, I was just sort of asking generally. It says August, '95, to July of 2001, instructor in the Department of Obstetrics and Gynecology. And August, 2001, to present, Assistant Professor.

A. Okay.

Q. Okay. Are you still within the Division of Obstetrics and Gynecology as well?

A. Yes, I am.

Q. Okay.

A. I am approximately 60 percent time in the Division of General Obstetrics and Gynecology.

Q. And just very briefly, what are your duties as the assistant professor in the Department of Obstetrics and Gynecology?

[11]

A. I have a variety of duties within that department. Certainly, for 60 percent of my time, I function as a member of the general Division of OB/GYN and see typical obstetrics and gynecology patients, delivering babies, performing surgeries that gynecologists would typically perform and teaching those methods to our residents and our medical students.

Q. How many babies did you deliver last year?

A. I would have to look to be certain, but I often deliver around a hundred babies per year.

Q. Okay.

A. Continuing, I wear several other hats within our department, so to speak. I am director of Prentice Ambulatory—medical director of Prentice Ambulatory Care and Surgery which are the outpatient clinics of our residency training program.

These are also patients who come for general obstetrics and gynecology care but see our residents for their care who are also backed up by a number of attendings within our [12] department.

In addition to overseeing that division, I am director of medical student education at Prentice Women's Hospital site and assistant director of the division of undergraduate education for our department.

This means that I coordinate medical student education for third-year medical students who are in our department.

I am also the gynecologist for the HIV program at Northwestern Memorial Hospital. I am one of the gynecologists at the Rehabilitation Institute of Chicago, and I am director of Northwestern's program in family planning and managing director of the fellowship in family planning.

Q. How many fellows do you have in your family planning program?

A. We currently have two fellows. We accept one fellow per year.

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Q. What percentage of your time is spent as the director of the Northwestern family planning program?

A. It's hard to say an exact percentage. At least 20 to 30 percent of my time is spent either managing the program or performing clinical responsibilities related to the family planning program.

Q. What's the patient population of the Northwestern family planning program?

A. The patient population of the Northwestern family planning program consists of [14] those patients for which I am responsible at Prentice as well as patients with whom our fellows might interact at other sites. I am not involved with those sites.

At Prentice, our patient population consists predominantly of women who are referred to myself for

pregnancy termination procedures, most commonly procedures that are needed either based on maternal health or fetal indications.

Q. When you say that the patient population includes those patients that you have at Prentice, are you referring to patients in connection with your position as the medical director of the Prentice Ambulatory Care Clinic?

A. Not directly.

Q. Okay.

A. The patients who are part of our family planning program are really referred from throughout our institution and also from throughout this area.

We have patients who are in need of pregnancy termination services who cannot obtain them in other parts of Illinois or at other institutions within Chicago. And we receive [15] referrals routinely from a variety of physicians whose patients need our services at those other institutions.

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[18]

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Q. I see. What types of abortion services do you provide?

A. I provide abortion services for patients referred to us through the family planning service. Some of those patients are requesting pregnancy termination for "elective reasons." We perform those predominantly in the first trimester and not after 16 weeks' gestation.

The majority of the referrals that I receive are for patients requiring termination due to maternal and fetal indications, by which I mean maternal illnesses and also fetal anomalies or other problems of a troubled pregnancy.

Because many providers do not provide [19] services in the second trimester, a large number of our referrals are for patients who need these terminations in the second trimester of pregnancy.

Q. And what gestational age do you provide services for beyond 16 weeks?

A. We provide pregnancy termination services for maternal-fetal indications through 24 weeks' gestation.

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Q. And can you give me an idea of the types of referrals that you receive for maternal terminations for maternal indications?

A. We see a large number of maternal indications.

Q. I'm sorry. When you say "we," who are you referring to?

[24]

A. I am referring to the service at Northwestern.

Q. Okay.

A. The family planning program.

Q. Okay. Thank you.

A. The family planning program receives referrals for women with a variety of illnesses. As I stated in my declaration, I have had patients with malignancies such

as leukemia, breast cancer, and other malignancies who have requested or required termination.

I receive patients with intrauterine infections which is called chorioamnionitis who require termination on this basis, something that could be considered both a maternal or even fetal indication. I am—

Q. Why is that? How is that considered a fetal indication?

A. I think that the risk to the pregnancy, particularly the mother, is so great at this point that the pregnancy must be terminated.

Q. If the risk to the mother is so great that the pregnancy has to be terminated, how does [25] that make it a fetal indication?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Because chorioamnionitis is an infection of fetal material. It is an infection of the placenta and amniotic membranes.

BY MS. GOWAN:

Q. I see.

A. Therefore, it is indicated based on a fetal condition that is now jeopardizing maternal health.

Q. Thank you. What other types of conditions have you—maternal indications have you received referrals for while you have been at Northwestern?

A. I have had mothers with cerebrovascular abnormalities including aneurysms and brain tumors who have required termination.

I have had patients with very early forms of preeclampsia/HELLP syndrome, H-E-L-L-P, who have required termination.

I have had people with liver failure needing transplant who have required termination. I have had patients with very [26] severe diabetes, very severe coronary artery disease, whose doctors have recommended that they terminate pregnancies.

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Q. Well, I am asking are some of these your own patients, or are some referred to you by other obstetricians for the purpose of performing the termination?

A. I have patients like any obstetrician who will ultimately develop maternal health [28] issues or who are diagnosed with fetal anomalies. And certainly, if they are my own patient, because I am one of the few obstetricians who is on faculty who has the skills required to perform the termination, I will do so.

I would emphasize that the majority of the procedures that I am doing are referred by other obstetricians. And the majority of the patients, because of the complexity of their medical—excuse me, of their maternal medical or fetal issues, have already been counseled by a number of physicians before they come to my practice.

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Q. Okay. In the 20- to 24-week gestational age, can you give me an idea of what the percentage of the terminations you provide are by D&E?

A. At least 95 percent or more are by D&E.

Q. And what are the remainder? What's the method in the remainder?

A. Induction of labor.

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[47]

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Q. Okay. And what do you mean when you say that where the fetus is living, the period of time is less predictable?

A. I mean that the induction abortion time cannot necessarily be predicted, meaning that some patients might deliver within 24 hours, but one of the sad consequences of medical induction of labor in the second trimester is occasionally, a patient will undergo attempted induction for one or two or even three days, still without successfully aborting the pregnancy.

Q. How often does that happen?

[48]

A. I cannot give you exact percentages.

Q. I am not asking for exacts. I understand that you can't. I am asking for an idea.

A. I can't tell you—I cannot tell you for living fetuses how often the induction abortion time exceeds 24 hours.

However, I am consulted for this on probably at least a monthly basis by members of our Maternal-Fetal Medicine Division.

Q. When you say you are consulted on this, what do you mean?

A. As I mentioned earlier, many of my referrals come from our Division of Maternal-Fetal Medicine, so if they have a patient who is on the labor floor at Prentice or if somebody else at an outlying hospital has had a patient who for whatever reason has decided to undergo a medical induction of labor, and it has failed, and the patient is still unable to abort, they will then consult me to reconsider the method of abortion that was originally planned.

Q. Okay. And that occurs about once a month?

[49]

A. At least.

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[63]

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Q. Okay. So let's talk about 20 to 24 weeks.

A. The procedures are all similar in that the process begins with cervical preparation.

Most commonly, cervical preparation is [64] achieved by placing a form of osmotic dilator into the cervix on the day or two before the actual uterine evacuation occurs.

The most common form of osmotic dilator that we use are called laminaria which are a form of seaweed.

We have a protocol that we again vary according to patient, but in which we put varying numbers and sets of laminaria, dependent on the gestational age of the patient who is undergoing the D&E procedure.

Q. Okay.

A. Beginning 24 hours before the procedure is performed.

Q. Okay. I really want to know from 20 to 24 weeks, so tell me what are the varying numbers at that gestational age.

A. At 20 to 24 weeks, we typically place two to three sets of laminaria tents. Typically, after seeing and counseling the patient, we place a first set of laminaria.

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Q. Well, you were telling me about cervical preparation at 20 to 24 weeks, and we were talking about the use of laminaria tents.

A. Would you like to know our protocol at [66] 20 to 24 weeks for laminaria?

Q. Well, that's what you were telling me about.

A. Well, I can tell you our protocol is to place two or three sets of laminaria tents. These typically begin 24 hours before the D&E procedure.

After we have counseled the patient, the first set is placed. Later that afternoon, usually at least six to eight hours later since laminaria require four to eight hours to achieve dilatation, the patient returns, we take out the first set of laminaria and put in a second set.

Occasionally, depending on the clinical circumstances of the patient, we are able to achieve an adequate number of laminaria and adequate cervical dilatation that a second set will suffice for the procedure the next day. And in that case, no further sets are required.

Quite often, however, in patients between 20 and 24 weeks, a third set is required, in which case the patient returns the morning before her surgery which is typically at least four hours after this set and receives a third [67] set of laminaria tents.

Q. How often—and when you say typically a third set is required, how often is a third set required in your experience?

A. Without attempting to evade the question, it is very difficult to answer because there are so many variables that play into this, and we are seeing such an unusual non-homogeneous population of patients.

If the patient, for example, is multiparous and has had children before, her cervix will often be more pliable, and we will often be able to avoid the third set of laminaria.

If she, however, is nulliparous, has not had children before or simply has a more recalcitrant cervix, we may require the additional set.

Q. Is the process ever more than 24 hours before D&E in your practice?

A. Rarely, but occasionally, depending on the nature of the cervix. One of the things that I insist on with my residents and fellows is that we not perform the procedure until the cervix is [68] adequately treated, and if this requires waiting longer, then we

wait longer. It is exceedingly rare that this is the case, period.

Q. You have placed the laminaria, you have put in the first set, the second set, and the third set if required, and now, you are in the operating room. What do you do?

A. The first thing that we do—let me back up. Are you speaking only still about 20- to 24-week terminations?

Q. Yes.

A. Once we have arrived in the operating room, the patient is placed under general anesthetic. Once she is asleep, we place the patient in dorsolithotomy position, remove the laminaria, and I assess whether I think cervical dilatation is adequate.

Q. How do you do that?

A. I do so by feeling the cervix, checking not only dilatation, but also the softness of the cervix.

Q. Do you use an instrument to assess the cervix?

A. No, because the most appropriate way [69] at-least initially is by digital exam to feel the softness since a mere assessment of dilatation often doesn't tell you this.

Q. Do you ever use an instrument to assess the cervix?

A. Immediately before beginning the procedure, I will make sure that the instruments that I think I might need easily pass through the cervical os.

Q. And how do you do that?

A. After we have removed the laminaria, prepped and draped the patient, we grasp the anterior lip of the cervix with some type of tenaculum or other grasping device so that we can stabilize it during the procedure.

We then either pass a dilator through the cervical os or one of the common extraction devices through the internal os to make sure if there is any remaining question in our mind that the cervix is adequate.

I want to emphasize that we are not dilating and stretching the cervix at this point. We are only doing this in cases where we think we need to be absolutely more certain than [70] we were able to ascertain by digital exam that the cervix is adequately prepared because I never wish to start a procedure until I am certain that that is the case.

Q. So are you saying that you don't always use an instrument to assess whether the cervix is adequately prepared?

A. We very often do not need to. Depending on the nature of the pregnancy that is undergoing termination and the nature of my digital exam, I may well know immediately before the procedure based solely on digital exam that the cervix is adequately dilated.

Q. Do you know that in the majority of cases, based on digital exam?

A. Not necessarily. And I can't give you an exact percentage how often that is the case.

Q. I know you can't give me an exact. I am asking for a general idea. So do you use instruments to assess half of the time, or do you rely on your digital exam most of the time? Can you give me an idea?

A. I think that my digital exam is the most important determinant of my comfort [71] proceeding with D&E in at least 80 percent of cases.

And it is one reason whenever I operate with residents and fellows, that I am the only person who initially does the digital exam because I consider this so critical to determining my ability to perform the procedure and because it is something that is so dependent on the gestalt of the operator.

Q. Has your reliance on your digital exam for assessing cervical preparation increased over the years that you have been practicing and gaining experience with the procedure?

A. I was trained to check the cervix digitally and have always relied on this portion of the preoperative evaluation.

Q. What size instruments do you use in those cases when you assess with instruments?

A. We use the same instruments that we use for all of our D&Es.

Q. Are the instruments that you would use for the D&Es different at 20 weeks than they are for 24 weeks?

A. No, they are not. They are the same.

[72]

Q. And what instruments are you referring to?

A. We have a variety of extraction forceps. Hern forceps, Sopher forceps—Hern, H-e-r-n; Sopher, S-o-p-h-e-r; Bierer, and I hope I get this right, B-i-e-r-e-r; Vanlith, V-a-n-l-i-t-h, and others that are available.

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[73] * * * you are making your cervical assessment just prior to beginning the procedure?

A. We would not do this just prior if you mean immediately at the time when we are in the operating room with the patient asleep.

Q. Yes.

A However, we have used misoprostol for further cervical preparation. The most likely time that we would use misoprostol is in a patient who has a recalcitrant cervix who still has a very tight cervix during placement of a third set of laminaria the morning before her procedure.

Q. Do you ever use any mechanical dilators at the time that you are in the operating room to achieve greater dilation prior to commencement of the procedure?

A. We do this in first trimester procedures.

Q. I'm talking 20 to 24, Doctor.

A. It is very rare that we ever use [74] additional mechanical dilators. I do have some called the Hern, H-e-r-n, dilators, which can achieve significant dilation. In my experience, they have not been particularly helpful, and I am far more concerned that I achieve adequate dilation before I ever start the procedure which is one reason that I am so insistent that I digitally check the cervix each time before we start.

Q. What does the Sopher forceps look like?

A. The Sopher forceps is a serrated grasping instrument made of metal with a slightly rounded tip.

Q. Is the serration on the inside of the forceps?

A. Yes, it is on the inside of the forceps.

Q. And what is the outside of the forceps like?

A. It is a relatively smooth outside.

Q. And is that so when you put it into the woman's uterus, you are not—you won't mistakenly lacerate the uterus, or let me—do [75] you know why it is designed —try it again.

Do you know why the Sopher forceps is designed to be soft on the outside?

A. I think it is soft on the outside because if you had serrations or anything else, it could scrape the cervix and result in an injury.

I dislike the first way that you asked that question because laceration of the uterus is a very uncommon outcome of D&E and is best avoided by having a skilled operator.

Q. Okay. Is the Hern forceps also soft on the outside?

A. It is made of metal, but there are not serrations.

Q. "Smooth" is perhaps a better word than "soft"?

A. Smooth, yes.

Q. Okay. And is the Bierer forceps also smooth on the outside?

A. Yes, it is smooth on the outside.

Q. And the same with the Vanlith?

A. Yes.

Q. I don't want to discuss this at [76] length, but can you just very briefly tell me what the difference is in these different kinds of forceps?

A. The forceps—at Prentice, I have access to all of these different forceps for every D&E that I perform at all the gestational ages that I perform them. There are cases where some of the forceps may have certain advantages.

Q. Okay.

A. That are not necessarily related to gestational age.

Q. Why don't you tell me what some of the advantages of the different forceps might be?

A. The principal advantage of the Hern forceps are that the fulcrum of the Hern forceps * * *.

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[77]

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Q. Okay. Going back to you're describing the procedure for me, you have done your cervical preparation, the woman is in the operating room, you have performed your digital exam to assess the cervix, and if necessary, you have passed an instrument to insure that you have appropriate dilation. What happens next?

[78]

A. In most cases, the next step involves evacuating fluid from the uterus. I say "in most cases" because again, we see a very unusual population of patients including patients where there may be no amniotic fluid to evacuate. And in those cases, we obviously omit this step.

We typically place a 12-millimeter suction curette into the uterus and suction evacuate as much amniotic fluid as possible.

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Q. Okay. All right. You cut the cord, if that was possible. And you were just about to tell me about your work with the instruments.

A. At this point, we reach inside the uterus with an extraction forcep. Largely dependent on feel of the operator, we grasp a presenting part. Most commonly, we will grasp a lower extremity.

The object of the D&E is to evacuate the uterus with the fewest number of passes possible. This entails grasping as much of the fetus as we can, extracting those portions of the fetus with repeated insertions of the extraction forceps and then or at some point along this process, extracting the placental material.

Q. You grasp the fetal leg. What do you do?

A. We pull.

[82]

Q. Okay.

A. When we grasp the fetal leg, we try to pull as much of the fetus out as we possibly can at this point.

Quite often, we will meet resistance at the internal os of the cervix because that is typically the smallest diameter that the fetus has to traverse as it exits the uterus.

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Q. Okay. I noticed in the documents that you produced that you had Dr. Haskell's paper that was presented at that seminar. And in that paper, he refers to something called a "classic D&E." But apart from—did you notice that in his paper at all?

A. I have noticed Dr. Haskell's assertion that there is some distinction between D&Es in which the fetus is extracted more intact than in others, but I thoroughly disagree with the [96] concept that this constitutes a separate and distinct procedure.

Q. Why?

A. Because a D&E is a D&E is a D&E.

Q. Any other reason?

A. That is a very critical, crucial reason. All that Dr. Haskell has really done is to describe an evolution of standard D&E, a procedure that we have become familiar with during nearly 30 years of its evolution.

I do not believe the distinction of classic, traditional, or other methods of D&E really are describing a difference of intention or a difference in procedure, a difference in even philosophy than the majority of D&E providers have already initiated as part of their practices.

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Q. Before we took the break, Doctor, we were talking about those circumstances in which [113] the fetus was demised.

Have you ever had the occasion, in connection with performing a D&E at 20 to 24 weeks, to reach with your instruments and extract an intact living fetus up to the point where the head gets stuck in the internal cervical os?

A. Yes.

Q. Okay. And how many times has that happened?

A. I cannot tell you a number.

Q. Is it a large number?

A. I'm not going to be able to give you a number. Inherent in all D&Es as I have stated is an attempt to extract the fetus in the fewest number of passes possible to minimize maternal risk, so if I am able in confronting a fetus and demise has not occurred to reach in and extract at least that far, I will do so. And it does happen on occasion in our operating room.

Q. Okay. Can you give me an idea of how many times it has happened to you?

A. I would say that we have at least, at least three times per month when we are in a circumstance such as this.

[114]

Q. Why do you try to minimize the number of passes?

A. Because logically, the more that you have to traverse the cervix, the greater the likelihood with each of those passes that you can traumatize the patient, so if we minimize the number of times that we are having to put an instrument in, feel in the uterus and extract parts, we are decreasing the likelihood, the number of

chances we take of perforating the uterus and of injuring the cervix.

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Q. Again, I am trying to understand what you are describing. You were telling me about being stuck at the umbilicus.

A. The situation that I am describing is when the umbilicus has descended past the external os so that I can see the umbilicus has passed through, and I basically have the abdomen stuck at the level of the cervix.

Q. Okay. Now, what do you do to remove the remainder of the fetus in that circumstance?

A. We will in some cases make an incision [146] immediately inferior to the fetal umbilicus.

Q. What does "inferior" mean?

A. Immediately beneath.

Q. Okay.

A. Towards the—not to confuse us, but towards the extremities, that direction.

Q. Okay.

A. So we will make it immediately beneath the fetal umbilicus. And what this does is to also decompress. It gives us more room because any intra-abdominal contents are then able to extrude through the fetus, allowing me perhaps to be able to then regrasp the fetus superior then or higher on the fetus and continue the process of effecting as facile a delivery as possible.

Q. It may or may not then get stuck at the neck?

A. That is correct.

Q. Okay. Now, is there fluid in the abdomen that you are extruding?

A. Is there fluid in the fetal abdomen?

Q. Yes. You said that you would—well, I don't think you used the word "puncture," but that's the idea, right, you would puncture, and [147] then something would extrude. What is it that—

A. Well, it varies.

Q. I'm sorry?

A. Because keep in mind, I am doing these on fetuses that are often very anomalous.

Q. Okay.

A. And so if you ask could there be fluid, absolutely. We have deformities that have been sent to us where the fetus has significant ascites which by definition is abdominal fluid.

But in other cases, it is simply the internal abdominal viscera, the intestines, perhaps kidneys.

And again, the patients that I am seeing, oftentimes, there are fetal anomalies where the abdomen may actually be significantly enlarged precisely because of abnormalities with these viscera, so allowing them to extrude, taking advantage of the extra room we have in the vagina, may allow us then to complete more of the procedure intact.

Q. Got it. So at the point that you are puncturing the abdomen, the abdomen is still in the vagina, is that right?

[148]

A. It varies. And I can't answer that because again, different women are shaped differently. There are different degrees of pelvic descensus. And you could have a case if the cervix is immediately at the vaginal entroitis, where the abdomen is actually outside of the entroitis.

In other cases, if you have a patient with a prolonged vagina or who is just obese and you have a prolonged distance from the cervix to the entroitis, or in that case, yes, the abdomen is inside the vagina.

Q. How often has it happened that when you puncture the abdomen, that the umbilicus has been outside of the vaginal entroitis?

A. Once again, I have trouble giving you a number. I know—

Q. Well, has it ever happened?

A. Yes, it has happened that this is the case. And I cannot give you a precise estimate.

Q. Would that puncture effect fetal demise?

A. I think it's clear that extracting all of the fetal abdominal viscera will at some point [149] effect demise.

Now, if you are asking how long it would take, I can't answer that. I don't think I know. But I know if I do make an incision and carry out this act, that it will eventually at some point result in fetal demise.

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Q. Have you ever perforated a uterus in connection with a D&E by disarticulation?

A. Well, I am confused somewhat by "D&E by disarticulation" because to me, all D&Es are essentially the same. And most will involve some type of disarticulation, depending how you define that term.

Now, if you are asking have I had a uterine perforation, yes. Anyone who does enough of those procedures will have a uterine perforation.

And one of the things that I tell my patients is that if they are going to a provider who has not at some point in their training or practice had a uterine perforation, they are going to the wrong provider because that person is probably not doing enough D&Es, and they also don't know how to deal with a complication when [158] it arises.

Q. How many times has uterine perforation been a complication in a D&E that you have performed?

A. I couldn't say, but it is a rare complication. And I would say even in the course of the nine years that I have been at Prentice, it is fewer than ten times, so it is an exceedingly rare event.

Q. Do you know whether any of those times where that complication occurred, that you had performed—you had been able to extract the fetus intact up to the point where the head was stuck in the cervical os?

A. I know that that has never happened to me in those cases. In fact, one of the advantages of a D&E that allows you to proceed in a more intact fashion and one of the advantages of one such as you have described where the calvarium is above the internal os and some or part of the fetus remains below is you have greater

control and I believe probably less likelihood of perforation. I have not had one under those circumstances that you have [159] described.

Q. Do you consider a D&E where the fetus is not extracted intact up to the point of the head which is stuck in the cervical os to be a safe procedure?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. I would make clear that I consider a D&E in which the head is not delivered up to the—where the fetus is not delivered such that the head is trapped above the internal os as you described, that I consider those D&Es and other relatively more intact D&Es part and parcel of the same procedure, and I consider all of them safe procedures.

BY MS. GOWAN:

Q. Have you ever studied the advantages or I should say compared and performed a study that compares in some way the advantages and the disadvantages that you have described to me today of an intact removal up to the point where the head is stuck in the cervical os, vis-a-vis not having an intact removal of the fetus up until that point?

[160]

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Again, I don't believe that the procedure you are trying to distinguish is really a distinct procedure from those involving disarticulation. They are part and parcel of the same group of procedures which have been studied at length for 30 years.

I think that designing a study that looked at varying degrees of "intactness" would be incredibly difficult if not impossible to perform for at least two reasons: one reason is that D&E overall is an enormously safe procedure. And if you study any type of D&E, you have to have so many patients enrolled to be able to achieve statistical power to show meaningful differences between bad outcomes that it becomes very, very difficult to study the outcomes that are really in question.

For example, we would like to know how certain types of procedural variations might affect rates of uterine perforation, but uterine perforation is so uncommon, we usually in studies of D&E can't use that as an end point, so people [161] look at secondary outcome variables such as blood loss or OR time which aren't really as meaningful to the operators themselves.

The other problem with a type of study that you suggest is that because these are not distinct procedures, we cannot prospectively allocate patients to an intact or partially intact group versus a disarticulation D&E. The procedures do not exist separately from one another.

By that, when I begin to do one of these procedures, I am at the mercy of the cervix, the mercy at the vagaries of the cervix. I can't always tell simply by checking dilatation because it is also a functional acquiescence of the cervix. And the degree of intactness is to some extent what I get.

I know that I want maximal intactness because that follows based on common sense and certainly in my experience is safer, but designing a study to show it I

think is going to be very, very difficult, if not impossible.

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[169]

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Q. Okay. Why don't you do the injections?

A. There has not been a need in my department for me to do the injections.

First of all, we do have other people in the department who are able to do this and do so more frequently. I also do not believe that the injections are commonly warranted before abortion procedures.

Q. Why is that?

A. In order to commonly warrant an additional procedure, there would have to be some benefit that would justify a maternal risk.

I will grant that the maternal risks of giving a feticidal intracardiac injection are low, but there are still minor risks, and it is still an additional procedure.

[170]

The question, therefore, is what is the benefit that would justify doing this and particularly doing it on a routine basis. There probably is no such benefit.

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[186]

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Q. Have you observed a fetus that was born alive after induction abortion, second trimester?

A. In the course of my career, yes.

Q. What did you observe in terms of signs of life from the fetus?

A. Typically after the fetus is born, you may see spontaneous respiratory activity, you may observe a heartbeat. Occasionally, there will be what appear to be spontaneous movements. All of this depends on the gestational age of the fetus that is involved.

Q. Have you observed that at 24 weeks?

A. I have observed fetuses delivered at 24 weeks who exhibit all of those signs. And as I just testified, if I were doing a delivery of a * * *.

* * * * *

[192]

* * * * *

Q. Yes.

A. And I have had case—a case in which two twins were—two fetuses were conjoined and another was distinct.

And in this case, we felt that proceeding with an induction was relatively contraindicated, based on the type of conjoined twins that we were dealing with.

This was the opinion of maternal-fetal medicine specialists in my department and was one reason why we counseled the patient that D&E might be preferable.

Q. In that case that you just described to me, was either of the fetuses extracted intact up to the point where the head was stuck in the internal cervical os?

[193]

A. Well, that's one of the problems with this legislation is I think encapsulated in that very question.

Because fetuses that are conjoined such as this are not conjoined in the predictable fashion nor extracted in the predictable fashion that we might with a singleton pregnancy, I can't tell you how intact these fetuses were extracted, nor can I in terms of how this law defines an intact dilatation.

For example, the law that's in question would describe an intact dilatation as one in which any part of the fetal trunk is delivered above the level of the fetal umbilicus or navel, without demise having occurred.

And in the case of conjoined twins, it is conceivable, though I can't remember the exact extractions in this case, that I could easily grasp something above a fetal umbilicus or have extracted part of one twin to the level of the calvarium where the other remained inside.

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[195]

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Q. Do you think that D&E is safer than induction abortion at all gestational ages [196] beginning at 20 weeks going forward?

A. I think for those gestational ages that I perform, at 20 to 24 weeks, it is at least as safe and potentially safer.

I don't know that we have data substantiating that it is safer to the extent that we do with earlier second trimester abortions, but certainly, we have data that D&E at these gestational ages is safe.

Q. So you are saying at 20 to 24 weeks, the two are comparable in terms of safety? Am I understanding you correctly?

A. I think the two are at least comparable, and that based on data we have from earlier in gestation, we must assume that D&E, which is essentially the same procedure after 20 weeks as it is before 20 weeks, is at least as safe and maybe safer.

Q. When you say "we must assume," are you saying you, Dr. Hammond, assumes, or are you saying that the medical profession at large assumes that and it is written somewhere?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

[197]

A. I am saying that we, the medical profession, and particularly those of us who practice in institutions that have competent, trained providers of second trimester abortion, have to assume that in skilled hands, this procedure is at least as safe.

BY MS. GOWAN:

Q. And you certainly assume that, right?

A. About myself or about—

Q. Yes, yes.

A. I assume that D&E between 20 and 24 weeks in my hands is at least as safe as inducing labor.

Q. Okay. Are there any specific conditions, fetal indications in which you believe that the intact D&E procedure would be specifically indicated?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. I don't believe that there is an intact D&E procedure. And as I have testified, a D&E is a D&E. And I don't believe that the procedure really varies that much differently regard—regarding the specific fetal anomaly.

[198]

My intent with every D&E is the same, and that includes attempting to do the procedure as intact as possible.

BY MS. GOWAN:

Q. What, if anything, would you do differently if the law was upheld?

A. That's a difficult question because I want to obey the law.

On the other hand, I don't really know how we can have a law such as this one that fails to define the type of procedure it outlaws more specifically and that also fails to include a health exemption and still permit me to practice safe medical care or at least the safest medical care for my patients.

Q. Well, I understand that that's your view, but I am just asking you to assume for the moment that the law will be upheld. And what, if any—if at all, would that change your practice?

MS. CHAITEN: Object to the form. Asked and answered.

BY THE WITNESS:

A. I am afraid if this law is upheld, [199] that we will be compelled by the law to subject women to risk which they do not deserve to be subjected to. I think

this law has the potential to cause great harm to women, and that's one reason why I am here testifying.

BY MS. GOWAN:

Q. Can you tell me any concrete way in which—and maybe there isn't, and you can tell me that if there isn't—in which you feel that you would have to change the way you perform D&E if the law were to be upheld?

MS. CHAITEN: Object to the form. Asked and answered.

BY THE WITNESS:

A. Well, that opens up a wide array of things which I think we have been talking out—about throughout the day.

This law, first of all, is too vague. And as I have been testifying, it attempts to create a procedure that does not exist in medical practice. There simply is no procedure called partial-birth abortion.

And this law attempts to define the procedure in different ways. In its finding [200] section, it mentions, it alludes to several discrete steps and gives a definition and then doesn't allude to all of those same factors when it actually states the ban later on.

I believe that the way—and this is going to be a long answer because it is a long question—I believe that this law could potentially affect every D&E that I do because as I have mentioned time and again today, every time I sit down to start a D&E, I want to get appropriate dilatation, do the procedure as intact as possible, and I don't know a priori that I might not inadvertently do an extraction that qualifies through somebody's interpretation as being what this law specifies as outlawed.

So to the extent it is going to proscribe what 30 years of data has now documented as the safest method of terminating pregnancies, it will place my patients at risk, and by criminalizing it for me, will have certainly a chilling effect that may prohibit people like me from even taking the risk to give our patients the best medical care.

Without a health exemption, this law [201] also will place my patients at risk because as I have testified, I see patients who are terminating pregnancies because of their own health issues or fetal health issues. In many of these patients, this is the safest procedure that they can possibly undergo.

BY MS. GOWAN:

Q. Well, if the law is upheld, will you stop doing D&E?

MS. CHAITEN: Object to the form. He testified he doesn't know what he would do.

MS. GOWAN: I don't think he said that.

BY MS. GOWAN:

Q. Is that what you—you don't know what you would do if the law—you don't know how you would change your practice, if at all, if the law were upheld?

A. I think that I have testified that I don't know what we would do because I don't know what I would do because I want to obey the law, but this law is so non-specific, I don't really know what the law is outlawing.

Q. Okay. So you might change your practice, you just don't know what you would do?

[202]

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Well, and I think it is very difficult to ask a doctor if they would change their practice when they know that implementing those changes in their practice is going to harm their patients.

And make no mistake about it, if this law is passed and allowed to stand as is, doctors will necessarily have to take actions to protect themselves from violating this law that could place patients at risk.

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[233]

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Q. Has any patient ever asked you [234] specifically not to extract the fetus, her fetus to the point of the neck and then puncture the back of the neck and suction the contents of the calvarium?

A. No, but ironically, we have had patients specifically ask if we could do the procedure as intact as possible, that they would prefer it.

In fact, we had a patient just last fall who specifically requested this because she had a family member who was an obstetrician, had been aware that there were places trying to do this procedure intact, and she wanted to be able to hold the fetus after the delivery. And fortunately, we were able to do so for her.

BY MS. GOWAN:

Q. Why do you know didn't that woman select induction abortion?

A. Because she had a family member who was an obstetrician. And he realized that a D&E is still the safest procedure for his wife in this case.

Q. Did he tell you that, or you are just assuming that was why?

[235]

A. No. We were told this.

Also, many patients, once they hear descriptions of induction terminations and realize that they may confront not a few hours of induction but as we discussed earlier, one day or two days or three days of induction, immediately find it psychologically compelling to proceed with a procedure that can usually be accomplished in approximately 15 minutes, excluding the cervical preparation time.

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[316]

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Q. Do you do the internal podalic conversion?

A. Internal podalic version to most obstetricians and in most obstetric textbooks refers to a procedure that is performed in fetuses at or near term to deliver a living baby. It does not refer to any type of procedure that would be done during a dilation and [317] evacuation.

Q. Do you ever—

A. So I do occasionally, as anyone doing D&E does, convert a fetus that is vertex to a fetus that is breech. That's very commonly accomplished during D&E because as I indicated, the extremity is the easiest portion of the fetus to control.

Fortunately, we have 30 years of data substantiating the safety of this procedure and know that unlike internal podalic version at term, this is a safe procedure in these cases.

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[325]

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Q. So will cutting the cord in your view always be an overt act within the meaning of the Partial-Birth Abortion Ban Act of 2003?

A. I am uncertain whether it will always be an overt act, but I am certain that in some cases, it could be interpreted to be an overt act.

Q. Okay.

A. And I'm afraid might trigger the ban.

Q. Can you tell me what those circumstances might be?

A. I believe it would be triggered in a case, albeit a rare case, in which the fetus is presented vertex, has delivered the vertex vaginally, and an operator, in an effort to assist delivery, cuts the umbilical cord to permit further delivery.

This might happen, for example, even in an induction termination in which an operator encounters a tightened umbilical cord and needs [326] to cut the cord to extricate the fetus.

I believe it might also be triggered in cases of a breech presentation in which the operator has effected delivery with any part of the fetus exposed above the navel and then cuts the umbilical cord because I know that cutting the umbilical cord will eventually result in

fetal demise and could be interpreted as the overt act that the ban describes.

Q. The latter scenario that you have just described, were you imagining that the head was still lodged on the other side of the internal cervical os?

A. This could be one case.

However, the ban only specifies that the operator has delivered—and let me be careful of my wording—the ban states that any part of the fetal trunk past the navel is outside the body of the mother, so with an understanding of my concerns about the phrasing "outside the body of the mother" which I think we have already detailed adequately today, are more vague than they seem perhaps to a layman who does not do these procedures.

[327]

I believe that if I had delivered such that a part of the fetus above the navel were anything that would meet that definition and then cut the umbilical cord, I would be at risk of considering having violated this ban.

Q. In the context of the induction abortion—well, first of all, do you think the Act covers induction abortion?

A. Unfortunately, the Act is so badly worded, I think that it could be construed in such a way to include some induction abortions.

For example, under the section, "Partial-birth abortions prohibited," Section 1531, item (b)(1)(A), it says that, "The term 'partial-birth abortion' means an abortion in which the person performing the abortion—(A) deliberately and intentionally vaginally delivers."

An induction abortion is deliberate and intentional. The premise, the notion that this is somehow a natural event is fallacious because you are giving medicine to effect this delivery. Therefore, an induction termination is deliberate and intentional vaginal delivery of a [328] living fetus.

The ban then goes on to say in the case of a head-first presentation, the entire fetal head is outside the body of the mother.

Now, I have already I think more than covered my concerns about "outside the body of the mother."

But let's just imagine for a moment that a patient is on the labor floor who has been diagnosed with Trisomy 13, she is 18 or 20 weeks' gestation, and for whatever reason, does not wish to undergo a dilation and evacuation, and therefore, her obstetrician is inducing labor to cause abortion.

Let's assume that they effect delivery, but the fetal vertex delivers past the cervix and is entrapped by the umbilical cord. Admittedly, this may not be a common scenario, but my concern as an obstetrician isn't what's common, it's what could subject me to criminal prosecution, and in this case, what could subject obstetricians to even think they aren't violating the ban to prosecution because of the inept phrasing that is encompassed in this ban.

[329]

I think that if an obstetrician, despite the best of intentions of obeying the law in this case, cut the umbilical cord, there are people who might assume they had then performed the overt act that triggered the ban because they have deliberately, intentionally, vaginally delivered this infant. The vertex is beyond

the body of the woman, whatever that means, and they have now performed an overt act that they know at some point will trigger the demise of the infant.

Q. You don't know what "outside the body of the mother" means?

A. No.

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. And I think that we have stated this on several occasions, though I am happy to review it again.

BY MS. GOWAN:

Q. No, that's fine. If you just say no, I understand. It seems to me that you don't understand what "outside the body of the mother" means, is that right?

[330]

MS. CHAITEN: Object to the form. There has been a long discussion about this already today.

BY THE WITNESS:

A. And I will simply add as I have said on many other occasions previously today, that my understanding reflects an understanding of the functional anatomy that may not be apparent to people who don't do these procedures and perhaps a more realistic appraisal than the average layman would have of just how vague and just how difficult the term "outside the body of the mother" is actually to be defined in the context of some deliveries and in the context of the procedures that I do.

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[333]

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Q. If you wanted to reduce the degree of dilation of the cervix, could you do that by inserting a lesser number or a smaller laminaria?

A. Not necessarily. It's wrong to assume that this process is within our control to that extent.

When I place the laminaria, they aren't simply pushing the cervix open as we so commonly describe.

The laminaria are more complicated than that. The laminaria are actually changing [334] the cervical ground substance. They are changing the chemistry of the cervix, softening the cervix in addition to facilitating its dilatation.

Therefore, if I have a patient through whose cervical chemistry and parity is particularly amenable to the effect of laminaria, a small number of laminaria may actually effect great cervical dilatation.

Similarly, there are other patients whose cervical chemistry, parity, and other personal issues make her particularly more recalcitrant to the effect of laminaria.

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

DEPOSITION OF
CHARLES J. LOCKWOOD, M.D.
Feb. 17, 2004

APPEARANCES:

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* * * * *

[GOWAN EXAMINES LOCKWOOD]

[4]

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CHARLES J. LOCKWOOD, M.D., residing at 33 Liberty Street, Madison, Connecticut, being first duly sworn, as hereinafter certified, was examined and testified as follows:

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[15]

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Q. What had you heard about either Dr. Westhoff or Dr. Chasen?

A. That they were very accomplished, particularly Carolyn, very knowledgeable in this area, and very well respected.

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[23]

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Q. You don't have to read anything into the text if you don't want to.

A. I am going to comment on it, if that's all right with you.

Q. That's fine.

A So I think all that is valid and continues to be valid. "Unfortunately, the Act's language is so imprecise that it doesn't just prohibit that incredibly rare and truly horrific procedure, but also threatens all abortions." Let me stop there.

[24]

So this is a key issue obviously. I don't need to tell you that, and that is the issue of the vagueness of the Act. In my opinion, the wording of the Act is such

that I certainly can understand why the plaintiff's experts opined as they did in their expert reports.

Subsequent to writing this, I read the report to the judge that Ms. Gowan and her colleagues prepared. That raised the issue of intent and so here in fact is how my views have been modified.

So the issue is if the intent of the practitioner at the beginning of the procedure is to do a D&E and the procedure, through no fault of her or his efforts, leads to a D&X, would that person be liable to prosecution. This is really a legal issue, not a medical issue, but my understanding of the document was that a concept of mens rea held and that was that if the intent of the practitioner was to do a D&E and it evolved into a D&X, that that person would not be culpable.

So I would say that this is again a legal issue, not a medical issue. I am not qualified to comment on it one way or the other. However, I think that that needs to be adjudicated so we have some sense of whether or not that in fact does protect [25] the practitioner because if it does, you know, I don't see the issue here. The vagueness doesn't matter. So that would be one point.

The second issue is how would you make the language less vague. How can you craft an act that prohibits this form of abortion in a way that makes it crystal clear that it's not an alternative form of abortion. I think that's a very hard thing to do. That leads me back to my first point, which is the intent of the practitioner.

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[27] continue to agree with that?

A. I am sorry. Maybe you can actually read what we are talking about.

Q. It's in the next paragraph. "First, in my opinion it cannot be applied before viability," which is italicized, "because the "findings," a sort of preamble justification, fail to provide rigorous evidence that the procedure poses greater health risks than alternatives such as D&E, hysterotomy, or induction of labor."

MS. GOWAN: What's the question?

Q. Does that still reflect accurately the Doctor's opinion?

A. I have issues with the findings and the key issues I think are the risk of the procedure vis-a-vis the likelihood of an incompetent cervix. I mean, it's very reasonable to state that there is a positive, not an absence of data that support that position that Congress had and spelled out in their findings that there is some evidence, in fact, reasonably good evidence from both France and Denmark involving very large numbers of patients, over 10,000, in both studies that D&Es increase the risk of preterm delivery in subsequent pregnancies.

Now that observation doesn't prove [28] causality, but it does establish an association between D&Es and the occurrence of preterm deliveries. The D&X procedure, presumably the procedure to be banned in this Act is marked by a greater degree of cervical dilatation than one would, you know, cause to occur with a D&E.

And that would lead one to believe, at least theoretically, that the intact D&X might increase the risk of prematurity compared to a D&E because of the greater degree of cervical dilatation, presumably in-

creased trauma and so forth. However, that's a theoretical argument, and there is a paucity of data to support it.

Chasen's article, that's in press, that I reviewed I guess yesterday, which I didn't mention but now do is clearly inadequate in that there are not nearly enough patients to groups to draw meaningful conclusion. Of concern to me at least was that there was a higher rate of prematurity amongst the group that had had a previous D&X compared to the group that had a previous D&E.

Q. And no statistical—

A. Not at all.

MS. GOWAN: Objection.

A. And inadequate power. Absolutely.

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[30]

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Q. Now, just to go back to your draft of ed piece (Phonétic) which you thought was accurate at the time you wrote it, is it still your opinion that the findings set forth in the act failed to provide rigorous evidence that the procedure poses greater health risks than alternatives?

MS. GOWAN: Objection.

A. Well, I actually spent a good deal of time thinking about this. I think that the answer is that my view of the topic is as follows: That prior to 20 weeks, there seems reasonable evidence that D&Es are associated with fewer complications than medical abortions,

and that after 20 weeks, medical abortions appear to be associated with fewer significant complications than D&Es. There are a couple caveats.

The first is that the complications that are most commonly cited for medical abortions are retained placentas. One could argue that that complication is a less significant complication than the hemorrhages, lacerations and potentially more morbid but rarer complications that occur with a D&E.

So to summarize that statement, they [31] are not the same complications in general. After 20 weeks and particularly with the use of Misoprostol, there is a lower rate of retained placentas. That has to do with the biology of the placenta, and the way it adheres to the uterine wall. As the uterus is larger and the myometrium is thinner, there is an increase risk of perforation with a D&E. So that's sort of a summary of D&E versus medical abortions risks and complications.

D&X is a different procedure than a D&E. Chasen's very small study would suggest that there doesn't seem to be a substantial difference in the rate of complications between D&E and D&X, and so you could probably use the D&X—you could probably use D&E as a surrogate in assessing the safety of a D&X and make the same argument I just made, but again, there is no evidence. There is no good evidence to support the introduction of the procedure, nor is there evidence against its introduction.

Q. Let's go back to the previous paragraph, Doctor. Does it continue to be your view that, quoting the language in the penultimate sentence in the preceding paragraph, "The Act is flawed by its faulty assumptions of the maternal harm that accrue to [32] patients

undergoing a D&X by its vague description of the procedure to be banned."

MS. GOWAN: Objection.

A. I would argue that—well, that I have certainly done more homework than when I prepared this draft in terms of understanding in a far better way the complications of medical abortions and surgical abortions. I think that it's fair to say the converse that it is unclear to me that the D&X offers advantages over medical terminations and D&Es. I guess that would be—I know that's sort of sophistry, but still I think it's valid that, you know, the absence of data doesn't prove the absence of harm. That, in fact, medical abortions, D&Es, and D&Xs are certainly at least comparable, and particularly after 20 weeks, in terms of their safety. So that's a—I realize a very subtle change, but I think it is a different view.

Q. It's subtle enough that it may have escaped me.

This sentence seems to focus upon what you described as the faulty assumptions of maternal harm that accrue to patients undergoing a D&X. That is the faulty assumptions contained in the Act. Is it still your view that the Act's description and [33] findings of the harm—of maternal harms that accrue to patients undergoing a D&X are faulty?

MS. GOWAN: Objection.

A. I believe the findings exaggerate the risk of the procedure.

Q. In terms of the next page, if you would Doctor, the second paragraph of the page says, "Thirdly, the description of the actual procedure being banned is far

too vague and there is no limit on gestational age." Does that sentence continue to be your view?

MS. GOWAN: Objection.

A. Well, there is clearly no limit on gestational age. The issues of vagueness—is the language vague, yes. Does the Act, as constituted, represent a threat to the performance of a D&E? Again, I think this is a legal argument having to do with the intent of the practitioner.

Q. And when you say "vague," the language you used in December was far too vague, is that still—

MS. GOWAN: Objection.

A. Vague.

Q. So your view has changed in that respect?

[34]

A. Again, I am really not trying to mix, and mash, and finesse this. The bottom line is that this is a legal issue to me and not a medical issue. If the law is interpreted in such a way that the intent of the practitioner to perform a D&E is sufficient to render him not culpable to any of these penalties, then it's not vague in that sense. If it's not, then it's not only vague but worse.

Q. The matters that you and I just discussed here were also subjects that you and Ms. Gowan discussed last evening?

MS. GOWAN: Object to the form.

A. Well, I think I made comments. I don't believe she tried to lead me in those comments, if that's what you are eluding to.

Q. When you made comments, did she respond? You had a discussion about this?

A. Yeah, we discussed it, and I said pretty much what I just said.

Q. In what addition or number of Contemporary OB/GYN had you drafted this paper for?

MS. GOWAN: Objection.

A. That's not how it works. I draft lots of editorials. I have a few drafts floating around right now. It's when they actually get published, [35] when I actually send them and say, make this happen. This was certainly, I thought, a great topic for an editorial. I wrote it. I sent it to Sheila saying that I think this accurately reflects my view. I then got a copy of her report to the judge and made sort of the modifications that I just described in my mind at least, concerning vagueness.

Q. So that after you drafted this, you circulated it or you shared it with Ms. Gowan, correct?

MS. GOWAN: Object to the form.

A. I believe I e-mailed it to her. I can't recall exactly how I got it to her.

Q. Did you discuss it with her shortly after you e-mailed it or got it to her.

A. I think that by the time she responded to me, I had actually gotten the additional material that her office had sent me and voiced pretty much the opinion I just voiced, which was that this seemed now to be more of a legal issue than a medical issue. That the wording of the law, the Act was, in my mind, still vague, but that if there was legal—if a legal argument could be made and was bonafide, it's not for me to judge or to even

probably speculate on that anyone with the intent of performing a D&E was [36] protected, if you will, that that would change my opinion about the validity of the act.

Q. You had that discussion with Ms. Gowan after you sent—

A. Way back when, yes. Absolutely.

Q. And is it fair to say that your views, to the extent that they have been modified, have been modified on the basis of what you understand to be legal positions, and facts, and arguments rather than medical facts?

MS. GOWAN: Objection.

A. I have agonized over every aspect of this act and what it means for me, for society, for the country, and agonized is the correct word because it is an incredibly fine line between protecting the life of a potentially viable fetus and respecting a woman's right to choose. Being a maternal field medicine specialist, I think we are at the very front line of that dilemma, and so that is where I tried to sit myself.

Q. Let me ask my question perhaps a slightly different way. The agonizing that you have done, Doctor, has been in the wake of provision of legal argument to you in discussion with lawyers, not on the basis of any newly available medical facts, [37] correct?

MS. GOWAN: Objection.

A. No, both. Legal arguments certainly caught my eye, but I think that honestly the effort I have made to try to discern the relative safety of the three procedures has led me to conclude that they are comparable.

Q. Three procedures being D&E with dismemberment, intact D&E or D&X, and medical abortion or induction?

MS. GOWAN: Objection.

A. (Affirmative nod.) Correct.

* * * * *

MR. HUT: Let me ask the court reporter to mark as Plaintiff's 5 what appear to be three pages of notes.

(Whereupon, the three pages of handwritten notes was marked as Plaintiff's Exhibit 5 for Identification.)

Q. (By Mr. Hut) Doctor, the reason for my * * *.

* * * * *

[54] forces.

Q. You are Board Certified in Obstetrics and Gynecology, correct?

A. Correct.

Q. And likewise in Maternal Fetal Health?

A. Correct.

* * * * *

Q. As chair of the department of Obstetrics and Gynecology at NYU and prefatorily that you were at NYU as Chair how long?

MS. GOWAN: Object to form.

A. 1995 to 2002.

[55]

Q. And in 2002 or 2003, did you move to Yale?

A. 2002.

Q. And you were also, at Yale, Chairman of the Department of Obstetrics and Gynecology, correct?

A. Correct.

Q. As department chair at NYU, did you have responsibilities related to abortion?

A. Yes.

Q. Did you teach others any abortion technique or procedure?

A. No.

Q. Did you supervise abortions?

A. No.

Q. Did you hire physicians who performed abortions?

A. I did.

Q. What were the criteria used to do that?

A. The service was designed to be an academic service that provided training for the residents, clinical service for the patients, and also served as a contraceptive training and research service so that that service was also part of the national institute of child health and development contraceptive work. It would conduct clinical trials [56] in contraceptives. So the person hired had to be able to accomplish all those missions.

Q. How many such physicians did you hire?

A. Two.

Q. Who are they?

A. [REDACTED] who was at Bellevue for I believe a year-and-a-half, two years, and she was replaced by [REDACTED].

Q. Did both [REDACTED] and [REDACTED] perform intact dilation and evacuation procedure?

A. I know that [REDACTED] did.

Q. How about [REDACTED]?

A. I don't recall.

Q. Now, as Chair, you were responsible for what went on in the department, right?

A. Right.

MS. GOWAN: Objection.

Q. You were responsible for making sure that abortions as performed at NYU were safe, correct?

MS. GOWAN: Objection.

A. Correct.

Q. You wouldn't allow an unsafe procedure to be performed in your department, would you?

MS. GOWAN: Objection.

A. Correct.

[57]

Q. You wouldn't allow any innovation in technique that you thought was unsafe, would you?

MS. GOWAN: Objection.

A. Correct.

Q. Are you familiar with the form of abortion procedure called hysterotomy?

A. I am.

Q. You would agree, wouldn't you, that at virtually all stages of gestational age complication rates for hysterotomy are higher than for other forms of abortion, surgical or medical?

MS. GOWAN: Objection.

A. All other things being equal.

* * * * *

[62]

Q. Is it your understanding that no form of a D&E that begins with dismemberment is covered by the Act?

MS. GOWAN: Objection.

Q. Let me withdraw that question and rephrase it.

Is it your position that no form of D&E that begins with the position, either manually or by instrument, grabbing onto a fetal part with the intent of extracting as much of the fetus as possible is covered by the statute?

MS. GOWAN: Objection.

A. So this—we are back to the vagueness argument, and I would say this is a legal argument, not a medical argument. As someone who read the Act and hopefully interprets it in the correct way, it appears to me that the wording is such that the intent of the practitioner should be to deliver the fetus such that a portion of the fetus is outside the vagina, and then conduct some destructive act whether it's the ACOG destructive act or some other destructive act that is intended to kill the fetus and then does kill the fetus. That's how the wording would be interpreted by me.

Q. To your mind, does that include—does [63] that cover a D&E that proceeds by dismemberment?

A. I would hope not.

Q. Does it cover the situation in which the Doctor begins intending to extract a part of the fetus and does not know whether it will proceed by dismemberment or not?

MS. GOWAN: Objection.

A. Well, the wording of the Act doesn't address that. My understanding of the Act is that it has to be the intent—this is the argument that's been forwarded by the Attorney General and his representatives, is that it has to be the intent of the act—of the practitioner to do a partial birth abortion to do precisely what is characterized in the Act's language.

* * * * *

Q. (BY MR. HUT) Dr. Lockwood, could you please return to Plaintiff's Exhibit 5, which is the set of notes that you were helping us out with a moment ago.

The first line says that after 21 weeks D&X is probably safer than D&E?

A. That's what I wrote.

[64]

Q. Do you recall where you obtained that information?

A. This looks like it comes from the ACOG, the Committee opinion, but I am not sure where that comes from.

Q. You are not sure where the line that I just asked you about comes from?

A. Right.

Q. The following four components come from the ACOG Committee statement?

MS. GOWAN: Objection.

A. I don't believe the Committee statement says this. I'd have to actually look at it again.

Q. Do you believe that what you wrote there about the safety comparison between D&X and D&E is correct?

MR. GOWAN: Objection.

A. I believe when I wrote that, I probably thought that.

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[65]

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Q. Do you recall what the basis was for your belief at the time you wrote this statement?

A. Yes, I do actually.

Q. What was that?

A. That D&Es would involve multiple passes of the forceps into the uterus, whereas this procedure would involve hopefully one pass of a forceps.

Q. And that continues to be your belief about the way the procedures or the variations operate?

MS. GOWAN: Objection.

A. That's correct.

Q. When a physician sets out to do any D&Es, isn't it true that he or she intends to make as [66] few passes into the uterus or cervix as possible?

MR. GOWAN: Objection.

A. Correct.

Q. And the reason for that is that the fewer passes the less the risk of—or less the usage of instrumentation, and thus the risk of perforation or laceration, is that true?

MR. GOWAN: Objection.

A. And infection.

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[67]

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Q. If you understood that the person in the Justice Department responsible for enforcement of the ban had testified under oath that there has been no determination as to what procedures are covered and what are not, would that concern you?

MS. GOWAN: Objection.

A. Yes.

Q. If you would turn, Dr. Lockwood, to the third page of your draft statement, there you wrote—and I examined about this paragraph earlier but not about this sentence. The second sentence of the second paragraphs says "Thus, some people may interpret the Act as banning D&Es on 14-week fetuses with lethal anomalies, which places an "undue burden" on women seeking abortion in the second trimester." That accurately stated your view at the time?

MR. GOWAN: Objection.

[68]

A. It still does.

Q. The next paragraph states—actually, could you read that paragraph into the record, Dr. Lockwood?

A. "On a professional note I find distressing"—this was a draft, and I apologize for the grammar—"On a professional note I find distressing is the Act's imposition of criminal penalties on a physician who performs a "partial-birth abortion," further unraveling physicians' social contract with patients. Finally, I think it's entirely unconscionable for Congress to encourage civil suits."

Q. Does that continue to be your view?

A. Absolutely. Particularly the last sentence.

* * * * *

[73] question, and the answer is that I would differentiate a procedure where the intent was to deliver the fetus intact to the head, puncture the head, aspirate the cerebral contents, and complete the delivery from one where the fetus at 14 weeks was incidentally delivered intact or delivered to the point of the calvarium when it was the intent of the practitioner just to do a D&E. I think that that's a reasonable distinction to make.

Q. How about a gestational age later than 14 weeks? How about at 21 weeks?

MS. GOWAN: Objection.

A. Same.

Q. And so definitionally, you define an intact D&E as distinct from a D&X solely by virtue of what the physician intends to do, correct?

MS. GOWAN: Objection.

A. No. I mean, the procedures do have unique aspects that are not absolutely discriminating but do

define the nature of the procedures being distinct. For example, in an intact D&X, the cervix is dilated to a greater degree than would be necessary for a D&E.

Q. How about for an intact D&E?

MS. GOWAN: How about what? I am * * *.

* * * * *

[76]

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Q. Let me ask you this: When in your understanding as the procedures were performed at NYU, for example, under your Chairmanship, when does a physician form an intent to do either an intact D&X or dismemberment D&E?

A. Again, this is the basis of my conversations with [**REDACTED**]. Just to put things into perspective, I gave her wide latitude to do the procedure to do D&Es, and to train the residents in doing them.

I recused myself from making decisions at the borderline of viability in favor of an ethics panel at Bellevue. So if someone was 23½ or actually in New York State 25½ weeks, because you could use the point from conception rather than the menstrual date, they would discuss it, and a decision would be made by the panel. She was given wide latitude to makes these decisions.

Frankly, to be really honest with you, [77] my assumption was that she was doing D&Es, and when I talked to her, whenever that was in December or November, she said no, no, no. Because I asked her what she had done the last year. She said no, no, about two

thirds of them were D&Es, but a third of them were D&X. Define D&X. Deliver the fetus to the head, aspirate the calvarium, and deliver the fetus. And how would you decide to do one versus the other? Teaching extended cervical dilatation and so forth.

In her mind, and now I am talking about what was in her mind, there may be some objection that somebody would raise about that. But my sense was that the decision was made most often sort of during the performance of the procedure to reflect the needs to teach and the extent of cervical dilatation.

So she sort of had the option of going either way in some cases. In some cases, obviously, the cervix was very dilated. She might just go ahead and effect the D&X. And in others where it wasn't, even if that were her original intent, she might have done a D&E. Does that address that?

Q. I think it does. The extent of the preparation for both procedures, for either procedure at the same gestational age would be the same, [78] correct?

MS. GOWAN: Objection.

A. They certainly overlap.

* * * * *

[80] * * * by grabbing another fetal leg with the forceps, and at that time, through the application of traction, extracts the rest of the fetal body to the head, as you understand the act, Doctor, is that covered or not?

MS. GOWAN: Objection.

A. No.

Q. Can you explain in the language of the statute why you think it is not?

MS. GOWAN: Objection.

A. With the caveat that you are now asking me to explain to a lawyer the law. With that having been stated, okay.

So it says "The term 'partial-birth abortion' means an abortion in which the person performing the abortion (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother."

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[81]

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Q. (BY MR. HUT) Accepting the factual predicate that I articulated in the previous question and asking you whether so far in the statute the Act that I described would be covered.

A. No.

MS. GOWAN: Objection. There is no question pending.

MR. HUT: There was a question pending.

Q. Why not?

A. Because it says deliberately and intentionally.

Q. How is it that in the situation that I described, the physician is not deliberately and intentionally, in

the case of a breech presentation, delivering any part of the fetal trunk past the navel to a point outside of the body of the mother?

MS. GOWAN: Objection.

A. Because his intent was to disarticulate the remaining leg, that was his intent, and he was not [82] deliberately trying to deliver the fetus to conform to the rest of the statute.

Q. Do you see any words or language in the statute that would exempt from liability a physician for or in the situation where he or she is deliberately and intentionally wanting to disarticulate a portion of the fetus?

A. Yes.

MS. GOWAN: Objection.

Q. Where do you see that?

A. Deliberately and intentionally.

Q. Deliberately and intentionally delivering a living fetus, right, the Doctor is doing that?

MS. GOWAN: Objection.

A. Right, but that was not either his intent or deliberation. His intent was to disarticulate the leg. He didn't deliberately deliver the fetus at the women's introitus.

Q. I hope I am not appearing to argue with you. That is certainly not my intent, but the deliberateness and intent required is the vaginal delivery of a living fetus in the case of a breech presentation to any part of the fetal trunk past the navel. Nothing about the intent to disarticulate or [83] to dismember, is that fair?

MS. GOWAN: Objection.

A. No, it's not fair. Let me try to rearticulate why it's not fair as opposed to disarticulate. The argument is deliberate and intentional vaginal delivery. When you go to disarticulate a lower extremity and the fetus happens to come out, that's neither deliberate nor intentional.

Q. Is there anywhere in the statute where the deliberation and intent is limited to the extraction of an intact fetus?

MS. GOWAN: Objection.

A. I guess we are looking at the glass as half full and half empty.

Q. Would you agree that it's susceptible to be interpreted either way?

MS. GOWAN: Objection.

A. Well, I think you can look at glasses as half full or half empty. I have no objections to that at all, but I do object to your line of inquiry.

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[84]

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Q. Apart from the Act, as you understand [85] the D&E practice, understood the practice at NYU, didn't all the physicians want to extract as much as possible at one time intact, if at all possible?

MS. GOWAN: Objection.

A. I think that it's fair to respond by saying their eager to minimize the number of passes.

Q. Doesn't that inevitably mean that if they can, they are going to extract it intact if possible?

MS. GOWAN: Objection.

A. Their intent is to make as few numbers of passes as possible, but the presumption—their presumption, their intent is to disarticulate, and very often the head, the calvarium, will stay or some other body part might persist.

Q. Do they care whether they disarticulate or not as long as they extract with the fewest number of passes and intact as possible?

MS. GOWAN: Objection.

A. You are asking me to know their minds.

Q. In effect I am, Doctor, because you are making a fundamental distinction on the basis of what you perceived to be physician intent. So necessarily you, and I, and Judge Casey, Judge Cop (Phonetic), and Judge Hempton [Phonetic] are all going to have to get [86] into this.

Do you think they care about disarticulation or have any intent with respect to this disarticulation as opposed to the evacuation of the uterus with as few passes as possible—

MS. GOWAN: Objection.

Q. —intact, if at all possible?

A. My opinion is they probably don't.

* * * * *

Q. Let's take a case in which a physician, say at 20 weeks gestational age, believes that he or she is going to perform a D&E by dismemberment, inserts the

forceps through the cervix into the uterus grabs a fetal part, and that fetal part turns out to be a chest or torso, extracts that, you would agree that that is a part of the fetal body past the navel?

MS. GOWAN: Objection.

A. Strictly speaking, yes.

Q. In that instance, the physician would [87] have deliberately and intentionally vaginally delivered such a fetal part?

MS. GOWAN: Objection.

A. If I am reading the Act correctly it says "Deliberately and intentionally vaginally deliver" whatever that means "a living fetus until in the case of a head-first presentation the entire fetal head is outside the body of the mother, or in case of breech presentation, any part of the fetal trunk past the navel outside the body of the mother."

As you are describing a transverse lie, when you remove the thorax, you are doing neither of those things. It's neither a breech presentation or a vertex presentation. You are neither delivering the entire fetus to the point of the navel, nor of the head. You are removing the thorax and removing it from the body.

I am really not trying to be a words smith here, but clearly that's not the intent of the lawmakers in passing this Act. Nor is it the way I, giving great liberty to the English language, would interpret the Act.

Q. Assume something other than a transgress. Assume a breech presentation, but in the process of performing a dismemberment D&E and grasping [88] a fetal part, it happens that the first fetal part extracted

is a thorax, so that that portion of the statute would apply, the breech presentation.

* * * * *

Q. (By Mr. Hut) Would you tell me whether you think that that situation would be covered by the Act and if not, then why not?

MS. GOWAN: Could you read back Mr. Hut's question, please, and the predicate for it?

(Whereupon, the requested portion of the record was read by the reporter.)

MS. GOWAN: Objection.

A. No.

Q. And why not?

A. Because it was neither deliberate nor intentional. The intent was to grab whatever was there. It turned out to be the thorax. That was removed. It was neither a vaginal nor a vertex or breech delivery.

[89]

Q. Does it make any difference to you whether to extract a fetal head that's accomplished by compression with the forceps or other instrument as opposed to an incision and intracranial suction?

MS. GOWAN: Objection.

Q. When I say does it matter to you—

A. As long as it's not my head.

Q. Does that affect your definition or any distinction you make between an intact D&X and an intact D&E or dismemberment D&E?

MS. GOWAN: Objection.

A. It depends on the context.

Q. Can you elaborate on that?

A. Sure. In the context of this Act, if the intent is to vaginally deliver the fetus as a breech and then to either crush the skull or to aspirate the intracranial contents, that is clearly proscribed by the law. There is no doubt about that. If the intent was to do a D&E, and you happen to grab the calvarium and crushed it, and pulled it out, then that would not have been covered by the Act. So it doesn't matter to me. It only matters to me whether we are talking about the Act or not.

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[95]

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Q. Other than in connection with your work on this case, you don't regularly review medical literature concerning the provision of abortion, do you?

MS. GOWAN: Objection.

A. Of course I do.

Q. Even before your work on this case began?

[96]

A. I read the literature.

Q. Other than for purposes of this case, what was the last article on the subject of abortion that you read?

A. I've read vast literature on RU486. I suspect I read everything that's ever been published on it. And—

Q. How about with respect to second-trimester abortions? I apologize if I interrupted your answer. Go ahead and finish it.

A. I've read when the articles appear in the Gray or Green Journal or in other publications. I read. I try to at least cover the abstracts of most papers that are presented. As a Chair I need to know the literature.

* * * * *

[102] with it, so go ahead.

A. You presented two statements. The first was that this might be the only option to save a life and so forth. I would say that I cannot conceive of a circumstance where an intact D&X is the only option for terminating a pregnancy that is pre-viable the state of the fetus or after viability. That there are alternatives including medical abortions and very reasonable alternatives. If there is a circumstance that I can't conceive of where it is, then it should be done, but Potassium Chloride or Digoxin can be administered prior to the procedures.

As far as their statement, I suppose it's possible. I am not omnipotent. I don't know what that potentiality is, but there might be a possible situation where an intact D&X really would be the preferred route, but there are ways in which the practitioner can avoid violating the Act and still carry out the procedure.

Then in terms of the second statement, which is "The potential exist that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of women."

I would argue that that is not true [103] because, Number 1, there are incredibly few circumstances where this is the only option that's required. That assumes that D&E is available and that no one has, you know, any prohibitions against using it. It's used widely and freely, obviously. If there is a specific circumstance where the procedure, as described in the Act, is required, that it can be preceded by the injection of KCL, Potassium Chloride, or Digoxin and still be done.

You know, I think that the college position is a little different than my position. I think that as a rough rule of thumb, that medicine is best left to doctors to decide.

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[104]

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Q. My question is, with respect to the language that ACOG actually used, which was "The best or most appropriate procedure in a particular circumstance," do you agree that an intact D&X might qualify as such?

MS. GOWAN: Objection.

A. Well, I mean that's their interpretation. I think that my response was—I hope I articulated it—that I really conceive of no circumstance where, particularly after 20 weeks, there is an advantage to D&E versus D&X. There might be an [105] advantage to surgical abortion over medical abortion after 20 weeks in a setting where there was a previous C-Section or other uterine surgery that had been performed. Under those circumstances, rather than subject the woman to a po-

tential risk of Cytotec, or Misoprostol, or other agents that might increase the risk of rupture surgical abortion, is likely to be a better approach.

Is there a slight advantage of D&X over D&E in that context? Frankly, I don't think so, but if there is, and I am missing the boat here, they're some really rare circumstance that I am not privy to that there is the option of using Potassium Chloride or Digoxin, and that neither would present really an undue burden on either the Doctor or the patient to having the procedure done.

Q. With respect to the comparison of D&E versus D&X in that circumstance, you would agree, wouldn't you, Doctor, that with a D&X there would be fewer passes?

MS. GOWAN: Objection.

A. Correct.

Q. And fewer passes would mean less risk of infection, or perforation, or laceration, right?

MS. GOWAN: Objection.

* * * * *

[106]

A. Correct.

Q. Why wouldn't that constitute an advantage, in that circumstance, of a D&X over a D&E?

A. I think the big issues, the big risks with intact D&X, as defined by ACOG here, for example, are in the internal podalic version, which is potentially a single—although it's a single pass, theoretically it may not be, but presume for a minute that it is, would create greater torsion and greater potential risk of lateral

laceration and of damage to the uterus than multiple passes directly in the center of the uterus where you are not taking a sharp instrument and flipping it laterally to try to affect an internal podalic version. So that has to be weighted against the multiple passes that would be required for a D&E.

I think the second area that is of some concern is in the actual destructive procedure with the calvarium abutting the cervix. It is possible to extend the incision on the calvarium to lacerate the cervix. Is it possible that in trying to collapse the skull you tear the cervix? Either of those things seem to be potential risks. Clearly they are noted in Steve Chasen's preprint. They can occur and apparently with relatively similar frequency to a [107] D&E as a matter of fact. Different sorts of risk are presented by the two procedures.

Q. With respect to D&E versus D&X, in the case of a D&E, there would be greater exposure of the uterus and cervix to sharp fetal fragments, true?

MS. GOWAN: Objection.

A. Correct.

Q. Now with respect to the potential risks from podalic version, I take it that you would not have a problem if the fetus was presenting in breech?

A. Right.

Q. However, if the physician intends to perform a D&X, even with a fetus presenting in breech, that would be banned by the statute, correct?

MS. GOWAN: Objection.

A. Correct.

Q. Dr. Chasen found no greater risk of laceration from podalic version, isn't that right?

MS. GOWAN: Objection.

A. He found no greater risk to the procedure. Is that what you are saying?

Q. That's what I intended to say, and I didn't say that, yes.

A. And that's exactly my point.

Q. So no greater risk between D&X and D&E, [108] even though podalic version may have been performed in the course of—

A. Right, but the preface to this line—

Q. —during the intact D&E?

A. —of inquiry was that the D&X offered select advantages to the D&E. Clearly we can't prove that either based either on publications, more with Steve's article, and although it may be safer, it may not be safer, and I believe most likely it's probably equivalent to a D&E in terms of its overall risks and benefits.

Q. Do you know of any complication in terms of laceration or perforation that you ever heard and ascribed to the performance of a D&X and particularly the podalic version aspect?

A. No.

MS. GOWAN: Objection.

Q. With respect to the destructive procedure that you described, isn't there as much a risk from the collapse of a fetal skull with forceps, in terms of laceration or perforation, as there would be with incision and then suction of intracranial content?

MS. GOWAN: Objection.

A. Well, I think that the risk—the [109] different—I hate to be a word smith, but the difference between the two procedures are that it is the scissors or the scalpel that's opening up the calvarium that presents the risk to that part of the procedure as opposed to catching some of the cervix in the Sopher clamp when you are doing the collapse of the calvarium. So there are sort of different kinds of risks.

Q. And you are not able to say that one is greater than the other, right?

A. Well, they are both sort of similar.

Q. You are not able to say that one occurs with any greater frequency in one procedure versus the other, are you?

A. Where's the data?

Q. Have you ever heard of complication in terms of laceration or perforation as a result of any incision into the skull or the suctioning of intracranial content?

A. Only based on what was written by Steve Chasen.

Q. Does he describe—

A. It doesn't really tell you how the lacerations occurred.

Q. Did you observe in Dr. Chasen's article [110] that the frequency of more severe complications was higher in dismemberment D&E that it was in the intact D&E?

MS. GOWAN: Objection.

A. My recollection now, based on whatever 12 hours of interval, was that they were pretty comparable.

Q. In terms of severity?

A. In terms of risk.

Q. I am trying to—

A. Further complications rates were identical.

Q. I am trying to distinguish, apart from complication rates, a qualitative assessment of the severity of the complications.

MS. GOWAN: Are you making a representation that that information is in the report to the Doctor?

MR. HUT: Absolutely.

MS. GOWAN: I object to the form of the question.

Q. (BY MR. HUT) I am asking the doctor whether he noticed any qualitative difference.

A. I am all over what you are saying. I'd have to the paper in front of me, but if I were [111] reading it, I think there was a more severe complication with a D&E, if I remember correctly, a perforation or something that wasn't present in D&X, but I would have to actually review it. Again, we are talking small numbers.

Q. Do you ascribe any significance to the fact that in Dr. Chasen's study D&X procedures were on average performed at a later gestational age?

MS. GOWAN: Objection.

A. Do I believe that has some kind of import to the performance of the procedure or rationale for the procedure?

Q. Does it have any import with respect to any comparison of the safety between the two procedures?

A. Way too small numbers to really give you a definitive answer, but you presume that it would increase the risk of the intact D&X since the later in gestation you perform any abortion, the higher the risk in terms of surgical abortion.

Q. So the fact that the two turned out in this retrospective study to have comparable complication rates, does that suggest that since the D&X procedures were, on average, performed later that they may in fact be safer?

[112]

MS. GOWAN: Objection.

A. Well, just as you objected to my saying that the preterm delivery rate was higher with D&X with such small numbers, I would say the same, that the numbers are vastly too small to really rule in or rule out any greater or lesser risk to either procedure. They both seem, at least in that small study, to have had comparable risk. If you had a study 10 times that size, you may discern subtle differences in the rate of complication.

Q. I want to get back to observations you had made about the availability of KCL or Digoxin. Are you aware of any studies that show KCL to be safe, when used to effect fetal demise prior to a surgical abortion in the second trimester?

A. Any studies that show that it's safe?

Q. Correct.

A. No.

Q. How about with respect to Digoxin, are you aware of any studies that show that the injection of Digoxin into the amniotic sac prior to a second-trimester surgical abortion is safe?

A. Yes.

Q. What study?

A. Well, there are two studies. I think * * *.

* * * * *

[125] fair summation.

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A. No. I think what I said or what I meant to say, maybe I didn't say it, was that I can conceive of incredibly a few situations where an intact D&X would be the only procedure that would be required to affect termination of pregnancy. And that in that very rare circumstance, which I can't right now imagine, Potassium Chloride or Digoxin would allow the practitioner to affect an intact D&X without violating the Act.

Q. And is it medically appropriate in your judgment, Doctor, in those few circumstances or incredibly few circumstances, if you posit for the moment that some exist, to require a physician to administer in a patient to receive either KCL or Digoxin in circumstances where the physician believes there is no benefit and some risk to administration of KCL or Digoxin?

MS. GOWAN: Objection.

A. If the physician wants to be in compliance with the law, I see a benefit.

Q. I am talking about a regime in which the law is not in affect prior to the—an enactment of law.

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[138]

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Q. Have you formed expert opinions with respect to safety based on safety statistics?

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A. Yes.

Q. (BY MR. HUT) And other than reading CDC literature, what would be the basis or what is the basis for the development of those expert opinions?

MS. GOWAN: Objection.

A. Knowledge of maternal fetal medicine, knowledge of fetal development, knowledge of embryology, knowledge of surgical complications of maternal physiology, knowledge of hemostatic systems, for which I think I have some significant expertise, [139] as well as my knowledge of abortion procedures from reading, from lectures, from observations, from GYN, M&M conference, with discussion with the practitioners, and from seeing many complications.

* * * * *

[140] you have described with perspective directors in the course of your recruitment efforts, have you talked about actual performance of abortion procedures, and safety data, and complications, and whether there are indications that would favor a particular circumstance as one procedure over another?

MS. GOWAN: Objection.

Q. Have you gotten to that level of detail?

MS. GOWAN: Objection.

A. We have talked about the different venues that the procedure could be done in. Should it be done at a women's center? Can it be done in a hospital? Should it be done at the Planned Parenthood? Should we arrange for some kind of joint program? What are the down sides to performing outside of the hospital or the advantages of performing them? What is the environment of New Haven County like for abortion practitioners, and what is the environment of Yale-New Haven Hospital? Is it conducive? Is it supportive? Are there problems? Are there things that need to be covered?

I think that, you know, we certainly tried to identify the strengths and weaknesses of the institution and the area in terms of both early MVAs, [141] medical abortions, D&Es, and although we haven't discussed intact D&Xs, that would be something that I would be willing to discuss, but it's not against the law to discuss it.

Q. Would you expect – do you know whether any of the individuals you have spoken to about assuming the directorship role currently performs intact D&Es?

A. I don't think I have addressed that.

Q. Would you expect to address it if the law were enjoined?

A. I would definitely want to discuss it, yes.

MS. GOWAN: Well, the law has been enjoined.

A. If the law were enforced?

Q. If the law were permanently enjoined.

A. If the law were permanently enjoined, would I discuss it?

Q. Yes.

A. That is an excellent question. One that I haven't thought of before. I think that the answer to the question, honestly, is no. I would leave it up to the provider, as long as I was confident in their competence and their ability to * * *.

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[142]

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Q. And would have no objection to such a person performing or teaching intact D&E, assuming that it were lawful to do so?

MS. GOWAN: Objection.

A. My role is to ensure that we are in compliance with the RRC's requirements to provide access to abortion training for our residents. One is to protect the health of our patients. Two, to make sure that the training is available, and three, do that in the context of an academic center means to conduct research and so forth. I'd expect all three of those things to be the keys to my decision. If intact D&Xs are being used, so be it.

I think that the same—I would apply the same rules and criteria for having decisions made about terminations after 20 weeks here that we did at NYU, which is to leave it up to the threshold of viability, leave it up to a panel and recuse myself from any of those individual decisions that would have to be made.

* * * * *

[154]

On the other hand, the issue—the counterbalancing issue—this is all speaking to moral ambiguity is the issue of protecting a woman's right to choose and being in compliance with previous Supreme Court rulings, and that sort of has two aspects. Is this procedure less safe as some have alleged than the other two procedures, and I don't think it is. It's pretty clear. Is it more safe? I don't think it is either. I don't think that it's either less or more safe than a D&E, and after 20 weeks, I suspect medical termination is safer than both.

So that if one argues that depriving women of the availability of this procedure would prevent the ability to have a termination, I don't agree. And as to its benefits in certain health circumstances, I don't agree with most of the comments made by the experts for the plaintiffs.

However, there may be circumstances, rare, that haven't considered where a D&X is required to protect the health and safety of the mother specifically, and if that's the case, then I would contend the availability of KCL and Digoxin to allow one to still perform the procedure. That's a very long winded response, and I apologize. I think it [155] summarizes my thinking about the case.

* * * * *

Q. Do you favor the right to have a termination via an intact D&X if that is the best procedure in the judgment of her Doctor and herself?

MS. GOWAN: Objection.

A. I believe that we should be aware that fetuses, particularly after 16 weeks and certainly [156] after 20 weeks, do have neurological function, can respond to pain, and that we should favor those procedures which minimize pain and permit full access of a women to make a decision about continuing her pregnancy.

So that what I guess I am saying or trying to say is independent of this act. I think that it behooves all practitioners to be as humane as they can, be cognizant that fetuses do feel pain, and the procedure that they choose ought to be chosen in a way to minimize that pain. Whether that means KCL or Digoxin for all, frankly, yes, I would favor that. Absolutely. Certainly after 16 weeks.

On the other hand, am I prepared to say that that's mandatory, no, because I think that the Supreme Court is correct and that the State shouldn't provide undue burden to access the procedure to abortions. But my personal preference is to minimize the pain and suffering of a fetus, certainly after 16 weeks and absolutely after 20 weeks.

Q. With respect to that question, Doctor, in the course of any D&E or intact D&X procedure that you have observed, have you seen any demonstration of fetal sensation to pain following the administration of the anesthesia?

[157]

MS. GOWAN: Can we have the question read back, please?

(Whereupon, the requested portion of the record was read by the reporter.)

MS. GOWAN: Objection to form and lack of foundation.

A. Number 1, I have never seen a D&X so, I can't comment. Number 2, it would be very hard to discern the response in terms of pain in a D&E if you are not doing an ultrasound to do it. Number 3, when you do an ultrasound, and I have and observed this certainly the fetus responds in a violent way to disarticulation and dismemberment. I think that the very elegant discussion of fetal neurodevelopment and the pathways and response to pain, as well as its ability and visual evoked responses, and now pet imaging, and through, you know, an analysis of neural anatomic pathways would strongly suggest that fetuses before 23 weeks and, in fact, sometime after 16 weeks do in fact feel pain, and after 20 weeks are likely to process the information in a way that we would view as sentient [Phonetic].

Q. You don't think there is any basis to you to distinguish whatever pain or sensation the * * *.

* * * * *

[162] exception to preserve the life of a mother with an exception to preserve the health of a mother?

MS. GOWAN: Objection.

A. Again, let me reiterate it for the sixth time. I don't perceive any condition where the health of the mother is better served by D&X versus D&E versus a medical abortion. There might be circumstances, however, and I have eluded to the possibility of having a previous uterine scar being one where particularly procedures done after 20 weeks are better done surgically than medically, but I don't see any necessary advantage. At this point there is no evidence in the

literature of this that the D&X would offer any specific advantages over a D&E.

However, as I said 15 times, there may be a circumstance, which I am unaware of, and in those circumstances, that treatment of KCL of Digoxin would allow one to do it and not violate the law.

Q. I completely understand that response, but let me ask you this: The act contains no exception where the procedure may be necessary to preserve the health of the women, correct?

MS. GOWAN: Objection.

A. Well, the wording is such that it could be interpreted as either health or life. And—

[163]

Q. What wording is that, Doctor?

A. This is S7(a). It says that—where does it say it? Maybe it's not here.

Q. It's actually in Subsection A as Ms. Sternberger reminds me.

A. "Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under title or imprisoned not more than 2 years, or both. This subsection does not apply to partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Clearly, any condition which endangers life would endanger health. I am sophistry. I admit it. The argument is that anything that endangers

life would also endanger health. So in that sense—in that narrow sense, it also protects the health of the mother.

Q. And if the statute did not contain the exception that you just eluded to, which you say in that sense exempts the procedure, if necessary, to save the health of the mother, would you believe it to [164] be appropriate in your medical judgment?

MS. GOWAN: Objection. You just asked the witness if a law was appropriate in his medical sense?

MR. HUT: Right. I want the answer.

MS. GOWAN: Objection.

A. So this is obviously an enormous issue, and one that we eluded to at the very beginning of this deposition, and that is how severe does a health problem have to be do justify the availability of abortion. Obviously it pertains more acutely to events that occur after viability. I would argue that there aren't any. Period. There is no circumstances where the life of the fetus needs to be forfeited to protect the mother's life. Period. End of discussion.

Prior to viability, any act, medical abortion, D&E, D&C, hysterotomy, you name it, any act affects termination of pregnancy by definition will result in the death of the fetus. So the issue then is the health of the mother endangered by the lack of availability of this procedure. I would answer to that by saying no. (A) because you still have medical termination which probably are safer after 20 weeks. (B) you still have D&Es prior [165] to 20 weeks, and (C) you can still do the procedure described in this Act, but you need to first treat the fetus with Potassium Chloride or Digoxin. I think I am answering your question.

Q. Let me just ask a couple of follow ups to make sure you are.

Despite the availability of hysterotomy, medical abortion, dismemberment D&E, is it your position that it is important that the statute contain an exception where a D&X intact is necessary to save the life of the mother?

MS. GOWAN: Objection.

A. It may seem that to say it doesn't need to have an exception for health and does need to have an exception for life is illogical, but I would say that when one is dealing with the health, there is less urgency than with life. If a patient's life is endangered, whatever the doctor thinks would work, great, do it. That's the top priority.

When a patient's health is endangered, I wouldn't say there is a luxury of time, but there is obviously more time available to consider other options, which would include medical termination, D&E, or using KCL or Digoxin.

There is an urgency that envelops [166] conditions where the life of the mother is at stake which don't exist where the health of the mother is at stake.

If someone has a medical condition, let's say cancer, where the termination of the pregnancy would allow chemotherapy and radiation therapy and so forth, then the delivery should be expedited, but does it matter which of those three techniques are available, no, not really.

If the mother is bleeding to death and she needs to be delivered immediately and the doctor only knows how to do an intact D&X, that's it. That's his whole

repertoire, well, in fact you are still not going to do it in that circumstance because she needs to be delivered by section, by hysterotomy, or what have you. She's bleeding to death, but if there is something in between those two extremes where the life of the mother is endangered and she can still wait three days to have the intact D&X, then I think it's reasonable that the law protect the practitioner and allow her to do that.

But you know reality, is there any circumstance where really the life of a woman would only be saved by waiting three days and doing a intact D&X as opposed to a D&E or medical abortion that could [167] be done potentially sooner, or quicker, or a hysterotomy. In all likelihood there is not, but what I am saying is give the benefit of the doubt to the mom. Don't preclude any procedure if her life is in danger and allow the physician to do that.

Q. But you would not give the same benefit of the doubt to the mother in the case of a condition that would permanently compromise her health?

MS. GOWAN: Objection.

A. Not as long as there are alternatives that would protect her health in exactly the same way—just as well and that are arguably less cruel or gruesome to the fetus. If that's not the case, then absolutely I would concur with you.

Q. In that life threatening circumstance, there is still the availability without compromising the speed of the procedure, in your judgment, to inject KCL or Digoxin, correct?

A. You are waiting two or three days for the Laminaria to cause cervical dilation, so you clearly have the luxury of time. Yes.

Q. Withstanding that availability, you would not require the Doctor in the circumstance where the condition affects or threatens to affect maternal life to administer KCL or Digoxin, correct?

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[185]

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Q. And I take it that you would agree that D&Es are performed in different ways by different doctors?

A. Correct.

Q. The steps that you outline on page 6, [186] 7, and 8 are not how every Doctor does D&E, right?

A. Correct.

Q. Doctors will vary the procedure in small ways, depending on the patient, depending on their own skill set, correct?

MS. GOWAN: Objection.

A. And training.

Q. But with your emendation, my statement is correct?

A. Correct.

Q. And I take it you would agree that physicians should not all be required to use the same exact technique for every D&E?

A. Correct.

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[193]

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Q. But you would have no objection, would you, to the inauguration of a longer period of dilation based on the intuitive judgments about its logical safety advantages?

MS. GOWAN: Objection.

A. Well, I never like support any intervention that hasn't been subjective to rigorous or at least some clinical evidence. It doesn't necessarily have to be randomized clinical trial. It can be retrospective in nature. There are such studies to support this verse Laminaria and do support it.

I think that what you are asking is * * *.

* * * * *

[197] doing a randomized clinical trial of D&Es at 18 weeks with or without Laminaria, no it's not, but there is certainly evidence, both sorts of crude evident and logical data given and other bodies of data that this a very reasonable, safe and reasonable approach to doing the procedure.

Q. How do you draw the line there, Doctor, between an innovation that would, in your judgment, benefit from initially a retrospective study and then perhaps some sort of more randomized controlled study versus a variation in an already established procedure, perhaps in a minor variation?

MS. GOWAN: Objection.

A. You know, it's really an important question because we grapple with it all the time. It's a continuum of innovation and some very minor. Like today, for example, we did a C-Section, and we just slightly modified the way we closed the uterus. I don't plan to

do that again, but it could be construed as a surgical innovation spurred on by the circumstances of that particular case.

At some point the modification of an established technique exceeds that sort of relatively trivial change and becomes an entirely new approach, and when that happens, I think you are obligated to * * *.

* * * * *

[208]

Q. If you understood or if you learned that providers of mid second-trimester surgical abortions dilate the cervix to the same extent for dismemberment D&E as they do for an intact D&X, would that affect your view as to the relevant safety of the two procedures?

A. Well, firstly I think they often do. I gave you the example of Bellevue. Two, I think that the procedures are very likely to be comparable. I think I have stated 17 times that I know of no evidence that an intact D&X is more dangerous than a D&E.

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[218]

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Q. Can inductions be performed before 15 weeks?

A. Theoretically it can be performed I wouldn't recommend it.

Q. Retained placenta is a potential complication of induction?

A. It's a complication.

Q. And your report indicates that there is a 10 to 30 percent chance of retained placenta?

A. Correct.

Q. Inductions sometimes fail?

A. Correct.

Q. What do you do if they do fail?

A. Depends on the circumstances. So one [219] option is continue, if there is no pressing need to move to another procedure and the alternative is to have the patient have a D&E.

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Q. And you contemplate the possibility that if the director who you are seeking to hire wishes to do so, that they would be taught at Yale, correct?

[220]

MS. GOWAN: Objection.

A. Yes, if it's legal.

Q. In performing a previability induction, does it ever happen that the fetus is partly expelled in breech presentation, but before the head is delivered, the woman becomes infected or sustains excess bleeding and the procedure must be completed with instruments?

A. Though it would be very unlikely that in a very rapid period that the head was retaining the calvarium and that the woman would become infected, but it's an unlikely scenario. The bleeding, however, could occur.

Q. And in the event that bleeding occurred and the procedure was completed with instruments, would one of the options available to the physician be to compress the fetal skull with forceps and facilitate the completion of the delivery?

A. Correct.

Q. The fetus could have indications of life while this occurred before the compression occurred?

A. Correct.

Q. And when a physician begins an induction, and the circumstances that I identified [221] occurred he doesn't know at the outset—sorry withdrawn.

When a physician begins an induction the physician may know at the outset that circumstances may occur and would necessitate the instrumental completion that you have just described, correct?

MS. GOWAN: Objection.

A. Correct.

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[230]

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Q. So as between dismemberment D&E and an intact D&X, one cannot conclude that there is any greater risk of AFE in respect to either procedure, can you?

A. Correct.

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[232]

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Q. Do the documented risks of conversion relate to periods closer to term when the uterine wall is thinner?

MS. GOWAN: Objection.

A. Of internal podalic version?

Q. Correct.

A. Yes.

Q. And the risks incident to internal podalic version are lower when ultrasound is available?

A. You would assume so.

[233]

Q. Doesn't your report make the same assumption?

A. Absolutely.

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[235]

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Q. Doctor, when a physician performs a D&E contemplating that it is going to be a dismemberment D&E and has not done anything intentionally or especially to achieve an intact delivery, does the physician in that circumstance know that he or she may achieve a delivery of an intact living fetus up to the head?

MS. GOWAN: Objection.

A. I think they would now.

Q. And would they before?

MS. GOWAN: Objection.

A. I think the key question is did they deliberately and intentionally do the procedure with that intent in mind or were they planning to do a D&E and it became an intact D&X.

Q. I am attempting now to focus not on the words deliberates intent but on the physicians' knowledge. Would the physician in that circumstance know that he

or she might achieve delivery of an intact fetus up to the head?

A. I think that anyone with the skill to do the procedure and sufficient experience knows that that is a possibility.

Q. And in that situation, the physician [236] would also anticipate that he or she might have to perform an action that results in fetal demise, right?

MS. GOWAN: Objection.

A. Correct.

Q. And to vary the question only slightly, at the outset of a dismemberment D&E, without having done anything special or intending to achieve an intact delivery, a physician may know that he or she may achieve delivery of a mostly intact living fetus, correct?

MS. GOWAN: Objection.

A. Certainly if the first point was true, then the second point is even more true.

Q. In that circumstance would have to or would anticipate having to perform an action that results in fetal death, correct?

MS. GOWAN: Objection.

A. True.

* * * * *

[237]

A. Well, there clearly would never be a condition where a medical termination wouldn't accomplish the same thing as a D&X. And there are many conditions where a D&E in publications, in fact, would achieve the same diagnostic value as a medical termination. There-

fore, I honestly can't think of a circumstance where it would be the only method that would allow one to produce an adequate pathological specimen.

Q. What about the following circumstances: An induction is contraindicated for the woman in question. The abnormality in question is not chromosomal, but it is in fact structural. In that circumstance, would it not be desirable and sometimes necessary to achieve as intact a fetus for diagnostic purposes as possible?

MS. GOWAN: Objection.

A. It would depend on whether or not the intracranial contents were a key part of that evaluation. Very many genetic syndromes involve abnormalities of the central nervous system. It didn't really matter whether you did a D&X or a D&E under those circumstances. You are not going to get good data in either case. If it were some limited circumstance where the pathology were confined to the [238] intraabdominal cavity, then it might be a better way to go than to do a D&E, but probably marginally beneficial. The key piece of information for many diagnoses are the intracranial contents, which need to be prepared in the correct way and so forth. Medical abortion would probably be a better way to do it. When I really am puzzled by a diagnosis I incur strongly encourage patients to opt for medical termination under those circumstances.

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[241]

Q. And at what point would cephalocentesis be performed?

A. It can be performed prior to the procedure being done, through amniocentesis. It can be performed

during the procedure when the head, if the head were in the vertex presentation, the contents could be aspirated, and/or it could be accomplished after giving Potassium Chloride and delivering the fetus to the head and aspirating the contents that way.

Q. If the head were lodged in the cervix during the procedure and cephalocentesis performed, that procedure would result in fetal demise, would it not?

A. Not in all. Not necessarily and certainly wouldn't have to be the intent of the practitioner to have that be achieved because aspiration of the cervixonal fluid would cause the head to contract. That was how we delivered viable pregnancies. I recall that even as a young fellow here that that would be the method of delivering these babies not intending in fact that they were to die.

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[PLAINTIFFS' EXHIBIT 6]

23 completed week gestation when the life of the fetus must be forfeit to preserve either the health of life of the mother. Thus, the State's obligation to protect the potentiality of life must be given full consideration after this point. Currently, a fetus born at 23 completed menstrual weeks following preterm labor could be aggressively treated and salvaged, while, in the next room, a patient has chosen to terminate a fetus at the same stage of development based on her personal choice. I do not believe that we can, as a society, justify spending billions of dollars to treat very premature infants desperately desired by their parents, while permitting the termination of similarly aged healthy fetuses. We must in some reasonable way balance the rights of a woman and the rights of babies, and draw a line on this slippery slope where there is a collision of two great forces—the right to choose and the right to life—both of which I support.

/s/ CHARLES J. LOCKWOOD, MD
CHARLES J. LOCKWOOD, MD

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695

NATIONAL ABORTION FEDERATION, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS CAPACITY AS
ATTORNEY GENERAL OF THE UNITED STATES,
DEFENDANT

DEPOSITION OF WAN J. KIM

Friday, Feb. 13, 2004

APPEARANCES:

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[6]

* * * * *

WAN J. KIM, Main Justice Building, 950 Pennsylvania Avenue, Northwest, Washington, D.C., called for examination by counsel for Plaintiffs and having been duly sworn by the Notary Public, was examined and testified as follows:

[WIGMORE EXAMINES KIM]

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[15]

* * * * *

Q. Are you currently employed by the United States Department of Justice?

A. Yes.

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[16]

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Q. And what position do you currently hold?

A. I am currently the Deputy Assistant Attorney General in charge of criminal, housing, [17] civil enforcement and education matters.

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[18]

* * * * *

Q. Are you part of a particular division of the Department of Justice?

A. Yes.

Q. What division?

A. The Civil Rights Division.

Q. What does that division do?

A. We enforce a number of statutes that in the main deal with instances of discrimination.

Q. Is your position that you currently hold a political appointment?

A. Yes.

Q. And did you receive that political appointment in 2003?

A. Yes.

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[20]

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Q. Do your responsibilities include criminal enforcement?

A. Yes.

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[24]

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Q. In your current position as the Deputy Assistant Attorney General, do you have any responsibility for implementing or enforcing the Partial-Birth Abortion Ban Act of 2003?

A. It's hard for me to respond to the question because I think it's—let me see if this is an answer, and then obviously you'll follow up. The Civil Rights Division is charged with the enforcement of the Partial-Birth Abortion Ban Act. There has been no imple-

mentation or enforcement as of this date based upon the orders issued by the three courts.

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[40]

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Q. Is there any Department of Justice policy or guidance or blue sheet on how the act will be enforced in the event that an injunction is no longer in force in one or more of the lawsuits challenging the act's constitutionality?

A. Are you asking me if there's a specific document that addresses the question of what we would do once the injunction—if the injunction is removed?

Q. That's correct.

A. No.

Q. And I want to change the question slightly and not reference a document, but whether there's just a policy, whether written or unwritten, as to how the Department of Justice will enforce the act in the event there's no longer an injunction.

[41]

A. No.

* * * * *

Q. And you are the person who's been identified in the interrogatories as the individual who has knowledge or information about the enforcement of the act, correct?

A. I am.

* * * * *

Q. Has the Department of Justice made any determination regarding what type of procedure or procedures will be subject to enforcement under the act?

A. Again, I don't sit here today as a representative of the Department of Justice. I [42] myself am not aware of such a decision.

Q. And again, you are identified as the person in the Department of Justice who has knowledge about enforcement; is that correct?

A. I am.

* * * * *

[65]

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Q. Sure. To your knowledge, does the Department of Justice have any final policy on whether the act will be enforced against procedures performed on fetuses that are not viable?

MR. HENRY: Same objection.

A. To my knowledge, I'm not aware of any final policy decision regarding how the act would be enforced. * * *.

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[68]

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Q. Is one of the issues that you have not yet tackled the scope of the procedures that will be subject to enforcement?

A. Oh, you're talking about the actual procedures by the physicians that are covered by the act?

Q. Yes.

A. Absolutely.

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[94]

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Q. Has the Department of Justice reached any final policy decision as to whether a physician must deliver the fetus intact in order to violate the act?

MR. HENRY: Objection, vague, asked and answered.

A. I am not aware of any such policy decision, final policy decision.

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[101]

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Q. Has DOJ reached a final decision or policy as to whether in cases in which a physician performs a partial-birth abortion as defined by the statute but could have saved the patient's life had he performed a hysterectomy, whether that would be a violation of the act?

A. DOJ has reached no final decision regarding any of the circumstances beyond what you see in the field guidance itself as far as I'm [102] aware.

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[115]

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Q. Has DOJ reached a policy decision as to whether the act bans only late-term abortion procedures?

MR. HENRY: Same objection as before. You can answer the question with respect to final Department of Justice policies.

A. As I've testified earlier, I am not aware of a final policy decision regarding terms beyond what was declared in the field guidance issued on November 5th.

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[116]

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Q. Has the Department of Justice reached any final policy decision as to whether the act applies to only one method of abortion?

[117]

MR. HENRY: Object to form.

A. I'm not aware of one.

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[122]

[EVANS EXAMINES KIM]

* * * * *

Q. For the purposes of my questioning, gestational age means how far along the pregnancy is. Has the Department of Justice made any final policy decisions about whether or not the act will apply before a fetus is viable?

MR. HENRY: Object as to form.

A. I'm not aware of any.

Q. And has the Department of Justice made any final policy decisions about how early in the pergnancy the act will apply?

MR. HENRY: Object to form.

A. I'm not aware of any.

* * * * *

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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03 Civ. 8695(RCC)

NATIONAL ABORTION FEDERATION, ET AL.,
PLAINTIFFS,

against

JOHN ASCHROFT, IN HIS CAPACITY AS ATTORNEY
GENERAL OF THE UNITED STATES, DEFENDANT

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

Civil Action No. 4:03CV385

LEROY CARHART, M.D., WILLIAM G.,
FITZHUGH, M.D., WILLIAM H. KNORR, M.D.,
AND JILL L. VIBHAKAR, M.D., ON BEHALF
OF THEMSELVES AND THE PATIENTS THEY SERVE,
PLAINTIFFS

v.

JOHN ASCHROFT, IN HIS CAPACITY AS
ATTORNEY GENERAL OF THE UNITED STATES,
AND HIS EMPLOYEES, AGENTS AND SUCCESSORS IN
OFFICE, DEFENDANTS

UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

No.: C 03 4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASCHROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

DEPOSITION OF
WILLIAM MOSCHELLA
Feb. 25, 2004

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

WILMER, CUTLER, PICKERING, LLP
By: AMY KRIEGER WIGMORE, ESQUIRE
KYLE M. DEYOUNG, ESQUIRE
2445 M Street, N.W.
Washington, D.C. 20037-1420

ON BEHALF OF THE DEFENDANTS:

U.S. DEPARTMENT OF JUSTICE
By: SHEILA M. GOWAN, ESQUIRE
86 Chamber Street, Third Floor
New York, NY 10007

AND

OFFICE OF ASSOCIATE ATTORNEY GENERAL
By: J. MICHAEL WIGGINS, ESQUIRE
BRIAN D. BOYLE, ESQUIRE
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-0001

ALSO PRESENT:

DONNA LEE, ESQUIRE, PLANNED PARENTHOOD

* * * * *

[WILLIAM E. MOSCHELLA—DIRECT EXAMINATION]

[8]

* * * * *

Q. Could you please state and spell your name for the record.

A. Sure. William, W-I-L-L-I-A-M, Emil, [9] E-M-I-L, Moschella, M-O-S-C-H-E-L-L-A.

Q. Would you please provide your business address?

A. Sure. 950 Pennsylvania Avenue, Northwest, Washington, D.C., 20530.

* * * * *

[11]

* * * * *

Q. How did you become familiar with that statute?

A. Well, I became familiar with it because before I worked at the Department of Justice, I worked on the House Judiciary Committee.

* * * * *

Q. Did you hold more than one position during the time you spent at the House Judiciary Committee?

A. Yes. The first stint I was just a counsel to the Committee. In the second stint, I worked for two different chairmen, and one as the Chief Oversight Counsel, and then one as the Chief Legislative Counsel and Parliamentarian.

* * * * *

[66]

* * * * *

Q. What did Bill Wichterman and Peter Coniglio discuss during their conversation, to the extent you know?

A. Scheduling, Senate scheduling of the conference report on this Act, this bill, I should say, S.3.

Q. Okay. Now, I want to turn to—I'm just going to read the first two sentences of the next paragraph so we have context. It says, "He said that Douglas Johnson of National Right to Life asked that the Senate not rush to conference on the PBA [67] bill. He believes that there is an advantage to waiting to see if a vacancy occurs on the SC, and then go to conference on PBA in conjunction with the vacancy." Did I read that correctly?

A. You did.

Q. And is it true that National Right to Life was recommending delaying finalization of the partial-birth abortion legislation in the hopes that a vacancy would emerge on the Supreme Court?

MR. BOYLE: Objection, form and foundation.

A. I really can't speak to that. I only know what's on this page.

Q. That's what Mr. Coniglio was reporting to you; correct?

MR. BOYLE: Objection, form.

A. He was reporting what this third sentence says.

Q. And the initials "SC" in that second sentence of the second paragraph, did you understand that to refer to the Supreme Court?

A. I did.

Q. The next sentence of the same paragraph reads, and this is the last sentence of the paragraph, "Johnson believes that the PR would be [68] advantageous to our side to wait and see if a vacancy occurs before going to conference on PBA, and Frist's office is inclined to go along with this strategy." Did I get that right?

MR. BOYLE: Did you read that right?

MS. WIGMORE: Yes.

A. I think it's an "of" instead of an "if" but otherwise you have read it correctly.

Q. And Mr. Coniglio was reporting to you that Frist's office was inclined to go along with the strategy recommended by Doug Johnson. Is that correct?

MR. BOYLE: Objection to form.

A. That's what he seems to be reporting.

Q. Do you have any reason to doubt the accuracy of that report?

MR. BOYLE: Objection to form.

A. No.

* * * * *

[69]

* * * * *

Q. Just referring you to the third line from the bottom of this e-mail, which reads, "For what it is worth, Bill W. said that Hatch is okay with this [70] too." Did I read that correctly?

A. Yes.

Q. Who does "Hatch" refer to there?

MR. BOYLE: What did he understand Hatch to mean?

A. I understood it to be a reference to Senator Hatch.

* * * * *

[Pl. Exh. No. 19]

[1]

Dilation and evacuation at ≥20 weeks: Comparison of Operative techniques

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[2]

In patients undergoing surgical abortion at ≥ 20 weeks, dilation and evacuation and intact dilation and extraction result in similar complication rates.

[3]

Objective: The objective of this study is to compare the relative safety of two techniques for surgical abortion late in the second trimester.

Study Design: Retrospective review of patients who underwent surgical abortion at ≥20 weeks' gestation at our hospital from 6/1996-6/2003. Records were reviewed to determine if the technique used was dilation and evacuation or intact dilation and extraction. Subsequent pregnancies at our hospital were identified, and obstetric outcomes were recorded. Categorical data were compared with Fisher's exact test and Chi-square analysis. Continuous data were compared with Mann-Whitney U test.

Results: 383 patients met inclusion criteria. Intact dilation and extraction was performed in 120 cases, and dilation and evacuation was used in 263. Intact dilation and extraction was associated with higher parity, later gestational age, and more preoperative cervical dilation. There was no difference in procedure time or estimated blood loss in the two groups. Complications occurred in 19 cases (5.0%), and occurred with similar frequency in the two groups. We identified 62 subsequent pregnancies. There were no second-trimester miscarriages. Spontaneous preterm birth occurred in 2 of 17 (11.8%) pregnancies in the intact dilation and extraction group, compared to 2 of 45 (4.4%) in the dilation and evacuation group (p=0.30).

Conclusion: Outcomes appear similar between patients undergoing dilation and evacuation and intact dilation and extraction after 20 weeks' gestation. Subsequent obstetric outcomes are similar between the two groups. The technique for surgical abortion should be determined by the physician based on intraoperative factors.

Key Words: Abortion, Dilation and evacuation

[4]

In the United States, induced abortion late in the second trimester is uncommon. In 1999, 9,643 abortions were performed at ≥21 weeks' gestation, representing only 1.5% of total abortions reported.[1] Dilation and evacuation is the most common method used for second trimester abortion,[1] and is considered the safest abortion technique in the second trimester.[2-5]

Dilation and evacuation involves preoperative dilation of the cervix using osmotic dilators, such as laminaria, which are placed in the cervix for one or more days prior to operative evacuation. All published reports of dilation and evacuation have described the use of grasping forceps to remove the fetus and placenta. Using forceps, fetal parts are grasped, and the fetus and placenta are disarticulated as they are removed. Low complication rates for this procedure have been reported.[2-5]

A variant of dilation and evacuation can be performed when sufficient cervical dilation is present. In these cases, the fetus is delivered via breech extraction. If the fetus is not in the breech presentation, internal podalic version may be performed. In most cases, after delivery of the body, the fetal head will become lodged in the cervix, and cranial decompression with suction must be performed to complete delivery. This

procedure has been referred to as intact dilation and extraction, or D&X. There is no published data regarding the frequency or complication rate of this procedure. Despite this, some have stated that this procedure poses serious maternal risks and is less safe than dilation and evacuation.[6,7]

The objective of this study is to evaluate the relative safety of dilation and evacuation and intact dilation and extraction in patients undergoing surgical abortion late in the second trimester.

[5]

Materials and Methods

This study was a review of patients who underwent surgical abortion at ≥20 weeks' gestation at the New York Weill Cornell Medical Center from June 1996 to June 2003. All procedures included in this study were performed by one of two physicians (STC and WKR) who are skilled in both techniques, dilation and evacuation and intact dilation and extraction. Institutional Review Board approval was obtained for this study.

Gestational age was confirmed by ultrasound in all cases. All cases ≥24 weeks' gestation were performed due to fetal demise. Dilation of the cervix was achieved with insertion of laminaria. Laminaria were placed preoperatively on two consecutive days, unless the cervix was sufficiently dilated at the initial examination. Women who went into labor following laminaria placement and delivered without dilation and evacuation of intact dilation and extraction were not included in this study.

The surgical technique was determined when the patient was examined under anesthesia, and was based on cervical dilation and fetal position. Both physicians

performing these procedures used similar criteria in determining the optimal surgical technique. All cases were considered complete when, after evacuation of the fetus and placenta, hemostasis was apparent after sharp and suction curettage. Blood loss was estimated by the surgeon. Procedures were performed in an ambulatory setting, unless patients had been hospitalized prior to the procedure for medical or obstetric conditions. The type of anesthesia used for the procedure, general, regional, or intravenous sedation, was at the discretion of the anesthesiologist. Intraoperative ultrasound guidance was not routinely used.

Operative reports were reviewed to determine the technique used in each case. If the fetus was delivered intact in the breech presentation to the level of the umbilicus or higher, the [6] procedure was considered an intact dilation and extraction, whether or not the entire fetus was removed intact or decompression of the head was required. In some cases, the presenting fetal head was well applied to the cervix, and was initially decompressed with suction, followed by intact delivery of the fetus. These cases were also considered intact dilation and extractions, as disarticulation with forceps was not required. All other cases, which were performed with multiple insertions of forceps, were categorized as dilation and evacuation.

Complications included any situation requiring unplanned intervention. These included unplanned hospital admission, repair of any genital tract lacerations, return to the operating room for additional procedures, and blood transfusion. Subsequent pregnancies at our hospital were identified from review of medical records. We did not obtain follow-up on patients routinely, so subsequent pregnancies with prenatal care obtained

elsewhere were not included in this analysis. 38 patients in this series, 26 of whom underwent dilation and evacuation and 12 of whom underwent intact dilation and extraction, were included in a prior publication describing obstetric outcome after second trimester abortion.[8]

Demographic characteristics and outcomes were compared based on operative technique. Categorical variables were analyzed using two-tailed Fisher's exact test and Chi-square analysis where appropriate. Mann-Whitney U test were used to analyze continuous variables, which were not normally distributed. Analysis was done using SPSS 11.0 (Chicago, Ill). A p value <0.05 was considered significant.

Results

383 patients met inclusion criteria. Intact dilation and extraction was performed in 120 cases (31.3%), and dilation and evacuation was used in 263 (68.7%). Demographic [7] characteristics of the two groups are listed in Table I. Intact dilation and extraction was associated with later gestational age, higher parity, and younger maternal age.

Indications for surgical abortion are listed in Table II. Preterm cervical dilation and/or preterm premature rupture of membranes (PPROM) were more common in those who underwent intact dilation and extraction. Abnormal fetal karyotype was more common in those who underwent dilation and evacuation.

Intraoperative variables are listed in Table III. Overall, laminaria were used in 96.1% of cases. Laminaria were less likely to be used in patients undergoing intact dilation and extraction. All 15 patients in whom laminaria were not used had preterm cervical dilation.

Preoperative cervical dilation was greater in those who underwent intact dilation and extraction. No differences were noted in procedure time or estimated blood loss between the two groups.

In the entire group of 383 patients, complications occurred in 19 cases (5.0%). Complications occurred with similar frequency in the dilation and evacuation and intact dilation and extraction groups (4.9% vs. 5.0%; p = 1.0). The 6 complications occurring in the intact dilation and extraction group included 4 gential tract lacerations (3 cervical mucosal lacerations and one perineal laceration) noted and successfully repaired at the time of surgery; 1 case of excessive bleeding requiring return to the operating room on the day of surgery for curettage; and one patient readmitted due to heavy bleeding on postoperative day 13 who underwent dilation and curettage for retained placenta.

Complications in patients undergoing dilation and evacuation included 4 gential tract lacerations (2 cervical lacerations and 2 labial lacerations) noted and successfully repaired at the time of surgery; 2 cases of excessive bleeding requiring return to the operating room on the day of surgery (for curettage in 1 case, and repair of cervical lacertions in 1 case); 2 postoperative [8] admissions for intravenous antibiotics due to endometritis; 1 admission for observation following excessive bleeding; and 1 admission due to severe nausea from general anesthesia.

Three patients, all of whom underwent dilation and evacuation, had complications requiring admission to the surgical intensive care unit. One patient, with a fetal demise, had an amniotic fluid embolus with disseminated intravascular coagulation requiring transfusion of blood and clotting factors. One patient was diag-

nosed with sepsis and pulmonary embolus. One patient had a uterine perforation at the site of a cesarean delivery scar, and required exploratory laparotomy and blood transfusion.

45 women (17.1%) in the dilation and evacuation group and 17 women (15.0%) in the intact dilation and extraction group had a subsequent pregnancy and received care at our medical center. There were no second-trimester spontaneous abortions in either group. Spontaneous preterm birth occurred in 2 of 17 (11.8%) pregnancies in the intact dilation and extraction group compared to 2 of 45 (4.4%) in the dilation and evacuation group (p=0.30). Both spontaneous preterm births in the intact dilation and extraction group occurred in women at high-risk for prematurity: one woman, who underwent intact dilation and extraction due to PPROM at 23 weeks' gestation, subsequently delivered at 32 weeks; the other underwent intact dilation and extraction at 23 weeks' gestation due to cervical incompetence with advanced cervical dilation, and subsequently delivered at 35 weeks.

Discussion

Based on this series of 383 patients, surgical abortion late in the second trimester is a safe procedure. There were low rates of complications in procedures with either technique.

[9]

As described in a prior publication,[9] we did not see a high rate of spontaneous preterm birth in subsequent pregnancies in those who received obstetric care at our medical center.

Because this study was retrospective, we cannot state that one technique is superior to the other. Proce-

dures performed with intact dilation and extraction occurred at later gestational ages and with more preoperative cervical dilation. While more advanced gestation might be expected to increase complication rates, more preoperative cervical dilation might be expected to facilitate these procedures.

Differences between maternal age, gestational age, and indication for surgical abortion were noted between the two groups. The difference in gestational age may be due to changes in the cervix that occur as pregnancy progresses. With advancing gestation, the cervix may be more likely to respond to laminaria placement with greater dilation. Intact dilation and extraction requires more dilation, as the intact fetus cannot pass through a minimally dilated cervix. In addition, more women in the intact dilation and extraction group underwent abortion due to premature cervical dilation or PPROM. The incidence of these conditions increases with advancing gestation, and the spontaneous cervical dilation occurring in these cases probably facilitated intact dilation and extraction.

The difference in maternal age is likely due the higher rate of fetal aneuploidy in the dilation and evacuation group. Amniocentesis is typically performed at 16-18 weeks, and advanced maternal age is the most common indication. Most cases of fetal aneuploidy are identified by 20 weeks. This could explain why those in the dilation and evacuation group were older, and underwent abortion at earlier gestational ages.

Our approach of performing intact dilation and extraction when possible is intended to minimize the use of forceps in extracting the fetus. We believe that use of forceps to grasp the [10] fetus can cause inadvertent trauma to the uterine wall. At these gestational ages,

evacuation of a fetus can require multiple insertions of forceps, and intact dilation and extraction avoids this. Though we believe our low complication rate validates our approach, we acknowledge that the retrospective nature of this study precludes us from concluding with certainty that intact dilation and extraction prevented adverse outcomes.

Another important limitation is the relatively small number of patients receiving prenatal care at our hospital in subsequent pregnancies. Most patients returned to their referring obstetrician for future obstetric care, and we were unable to assess subsequent pregnancy outcomes of patients delivered at other institutions. We believe that significant bias as a result would be unlikely, though we cannot be certain that outcomes in pregnancies followed at our hospital are representative of outcomes in all subsequent pregnancies. Though we are reassured by the low number of complications in subsequent pregnancies in both groups, we acknowledge our lack of power to conclude that subsequent pregnancy outcomes are not different.

Some have stated that intact dilation and extraction poses serious risks to the health of a woman beyond the risks associated with dilation and evacuation. Such putative risks include higher rates of cervical incompetence, uterine rupture, abruption, amniotic fluid embolism, and trauma to the uterus.[6,7] We are not aware of any published data supporting these statements. In our patients, the overall rate of complications was comparable between those undergoing dilation and evacuation and intact dilation and extraction. No patient undergoing intact dilation and extraction experienced uterine rupture, amniotic fluid embolism, or required blood transfusion. Because our approach is to perform

intact dilation and extraction when possible based on cervical dilation and fetal position, it is unlikely that intact dilation and extraction could have [11] been performed in these patients undergoing dilation and evacuation who experienced severe complications.

In conclusion, our data affirm that abortion after 20 weeks' gestation with intact dilation and extraction appears to have similar complication rates as dilation and evacuation when performed by experienced physicians. The observed complication rates and subsequent obstetric outcomes appear comparable between the two techniques. In accordance with the American College of Obstetricians and Gynecologists (ACOG) statement of policy,[9] our data supports that the most appropriate technique for surgical evacuation of pregnancy after 20 weeks' gestation should be based on intraoperative factors. Attempts to regulate intact dilation and extraction based on concern for maternal well-being cannot be supported by available evidence.

[12]

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[13]

Table I. Demographic characteristics of patients undergoing dilation and evacuation.

	D&E (n=263)	D&X (n=120)	p value
Median Maternal Age (range)	34 years (16-45)	32 years (12-43)	0.01*
Median Parity (range)	0 (0-7)	1 (0-5)	0.04*
Median Gestational Age at dilation and evacuation (range)	21 weeks (20-27)	23 weeks (20-25)	<0.001*
Prior Vaginal Delivery	81 (30.8%)	50 (41.7%)	0.05*
Prior Cesarean Delivery	49 (18.6%)	26 (21.7%)	0.49*
Multifetal Pregnancy	13 (4.9%)	8 (6.7%)	0.48*

*Mann-Whitney U test

†Fisher's exact test

D & E = Dilation and evacuation

D& X = Intact dilation and extraction

[14]

Table II. Indication for dilation and evacuation*

Indication for dilation and evacuation	D&E (n=263)	D&X (n=120)	p value†
Abnormal fetal karyotype	112 (42.6%)	33 (27.5%)	0.005
Structural fetal abnormality	96 (36.5%)	47 (39.2%)	0.65
Intrauterine fetal demise	27(10.3%)	14 (11.7%)	0.72
Premature cervical dilation/PPROM	14 (5.3%)	20 (16.7%)	0.001
Other	22 (8.4%)	13 (10.8%)	0.45

*Some patients had more than one indication

†Fisher's exact test

D & E = Dilation and evacuation

D & X = Intact dilation and extraction

[15]

Table III. Intraoperative variables

	D&E (n=263)	D&X (n=120)	p value
Laminaria	259 (98.5%)	109 (90.8%)	0.001*
Median Preoperative Cervical Dilation (range)	3 cm (0-6)	5 cm (2-10)	<0.001*
Anesthesia			
General	92 (35.05%)	53 (44.2%)	0.22**
Regional	9 (3.4%)	3 (2.5%)	
Local/Conscious Sedation	162 (61.6%)	64 (53.3%)	
Median Procedure Time (range)	22 minutes (6-60)	22 minutes (6-45)	0.54*
Median Estimated Blood Loss (range)	100 ml (40-1500)	100 ml (20-1200)	0.38*

*Mann-Whitney U test

**Fisher's exact test

***Chi-square anlaysis

D & E = Dilation and evacuation

D & X = Intact dilation and extraction

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF
CALIFORNIA SAN FRANCISCO DIVISION

Civil Action No. 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

Nov. 13, 2003

SUPPLEMENTAL COMPLAINT

Pursuant to stipulation of the parties and leave of Court granted at the specially-set hearing on November 6, 2003, *see* Order Granting Plaintiffs Motion for Temporary Restraining Order at 1 n.1 (Nov. 7, 2003), and pursuant to Rule 15(d) of the Federal Rules of Civil Procedure, Plaintiffs, by and through their attorneys, bring this supplemental complaint against the above-named Defendant, his employees, agents, and successors in office, and in support thereof state the following:

I. INTRODUCTORY STATEMENT

1. This is a constitutional challenge to S.3, the "Partial-Birth Abortion Ban Act of 2003" (to be codified at 18 U.S.C. § 1531) [hereinafter "the Act"]. The Act passed the House and the Senate and was signed by

President Bush on November 5, 2003. It became effective at 12:01 a.m. on November 6, 2003. A copy of the Act is attached as Exhibit A.

2. Plaintiffs seek declaratory and injunctive relief against the Act, which bans what the Act calls "partial-birth abortion." Those physicians who provide banned abortions risk criminal penalties and civil liability. The Act must be enjoined and declared unconstitutional because if suffers from the identical two constitutional flaws as the Nebraska statute banning so-called "partial-birth abortion" that was struck down by the United States Supreme Court in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000).

3. First, in contravention of the Supreme Court's clear holding, the Act bans abortion procedures without providing any exception for when such procedures are necessary or appropriate for the pregnant woman's health and without providing an adequate exception to protect women's lives. The Act thus deprives physicians of the discretion they need to make appropriate medical judgments regarding which abortion procedure to use, and requires physicians to use methods of abortion that impose unnecessary health risks upon patients.

4. Second, the term "partial-birth abortion," which is not a recognized medical term, is defined so broadly in the Act as to chill physicians from providing the safest and most common methods of abortion used in the second trimester of pregnancy prior to viability. The Act thus imposes an "undue burden" on the right to obtain previability abortions. Alternatively, the Act is so vague that it fails to give physicians fair warning of which abortion procedures are prohibited.

5. For these reasons, the Act violates the rights of Plaintiffs, their employees, their agents, and their patients to privacy and due process guaranteed under the Fifth Amendment of the United States Constitution.

II. JURISDICTION AND VENUE

6. Jurisdiction is conferred on this Court by 28 U.S.C. § 1331.

7. Plaintiffs' claim for declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of this Court.

8. Venue is appropriate under 28 U.S.C. § 1391(e) because administrative offices and healthcare facilities of Plaintiffs Planned Parenthood Golden Gate (PPGG) are located in this district, and PPGG provides abortions that may be banned under the Act in this district. Plaintiff Planned Parenthood Federation of America (PPFA) has a national office located in this district. Therefore, a substantial part of the events or omissions giving rise to the Plaintiffs' claims occur in this district.

III. PARTIES

A. Plaintiffs

9. Plaintiff PPFA is a not-for-profit corporation organized under the laws of New York. One of PPFA's national offices is located in San Francisco, California. PPFA is the leading national voluntary health organization in the field of reproductive health care. PPFA has 125 member-affiliates in 49 states and the District of Columbia. Cumulatively, Planned Parenthood's member-affiliates serve over 2.5 million patients per year.

Some Planned Parenthood member-affiliates provide second-trimester abortions that fall within the proscriptions of the Act, including dilation and evacuation (D&E) abortions, which are the most common method for performing abortions in the second-trimester of pregnancy. These Planned Parenthood member-affiliates reasonably fear that if they continue to provide second-trimester abortions, they and their employees and agents will risk criminal prosecution and civil liability under the Act. Some Planned Parenthood member-affiliates train medical residents in the provision of second-trimester abortions. These member-affiliates reasonably fear that if they continue to train residents in the provision of second-trimester abortions, they and their employees and agents, and the medical residents and their faculty supervisors, will risk criminal prosecution and civil liability under the Act. PPFA sues on its own behalf, on behalf of its member-affiliates that provide second-trimester abortions, on behalf of all current and future physicians, medical residents and their faculty supervisors, and all member-affiliate employees, staff, servants, officers, and agents who perform, participate or assist in the performance of, supervise, and/or train in the provision of, second-trimester abortion services at Planned Parenthood member-affiliates and/or on Planned Parenthood patients, and who are at risk of criminal prosecution and civil lawsuits under the Act, and on behalf of patients seeking abortions at Planned Parenthood member-affiliates nationwide.

10. Plaintiff PPGG is a health care provider that provides clinical, educational, and counseling services to men and women at 7 health care centers in the Northern Bay Area. PPGG provides a full range of reproduc-

tive health services, including: pregnancy diagnosis and counseling; contraceptive counseling; provision of all methods of contraception; HIV/AIDS testing and counseling; testing, diagnosis, and treatment of sexually transmitted infections; support services for pregnant women; cancer screening for cervical and breast cancer; colposcopy and cryosurgergy; and abortion services through 18 weeks of pregnancy as measured from the first day of the woman's last menstrual period (LMP), including D&E abortions. PPGG also provides primary care services. PPGG employs and/or contracts with physicians who perform second-trimester abortion procedures that may fall within the proscriptions of the Act, including D&E abortions. PPGG and its employees, staff, servants, and agents reasonably fear that if they continue to provide second-trimester abortion procedures, they will suffer criminal prosecution and civil lawsuits under the Act. PPGG sues on its own behalf, on behalf of its current and future physicians, medical residents and their faculty supervisors, and all PPGG employees, staff, servants, officers, and agents who perform, participate or assist in the performance of, supervise, and/or train in the provision of, second-trimester abortion services at PPGG facilities and/or on PPGG patients and who are at risk of criminal prosecution and civil lawsuits under the Act, and on behalf of its patients.

B. Defendant

11. Defendant John Ashcroft is the Attorney General of the United States and heads the United States Department of Justice, which is the agency of the United States government responsible for enforcement of federal laws, including the Act. Defendant Ashcroft is sued in his official capacity, as are his successors.

IV. THE STATUTORY FRAMEWORK

12. The Act makes it a crime for any physician "in or affecting interstate or foreign commerce," to "knowingly perform[] a partial-birth abortion." 18 U.S.C. § 1531(a). A "partial-birth abortion" is defined as:

> an abortion in which the person performing the abortion—
>
> (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus . . . .

18 U.S.C. § 1531(b)(1). This prohibition applies throughout pregnancy, regardless of fetal viability.

13. The Act contains a single limited exception. Only where a so-called partial-birth abortion "is necessary to saved the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury" is the Act inapplicable. 18 U.S.C. § 1531(a). The exception does not appear to apply to the Act's civil penalties.

14. Violation of the Act is punishable by up to two years imprisonment or a fine, or both. 18 U.S.C. § 1531(a).

15. In addition to criminal penalties, the Act provides for civil lawsuits. It allows the woman's husband, if she is married, or her parents, if she is under 18 years of age, to bring a civil action against any physician who allegedly performs a so-called "partial-birth abortion." 18 U.S.C. § 1531(c)(1). The plaintiff in such a lawsuit may seek, *inter alia*, money damages for "all injuries, psychological and physical," resulting from the so-called "partial-birth abortion." 18 U.S.C. § 1531(c)(2). A person whose criminal conduct caused the pregnancy or a person who consents to the abortion cannot be a plaintiff in such a civil action. 18 U.S.C. § 1531(c)(1). This provision thus operates as a *de facto* spousal and/or parental consent requirement for second-trimester abortions.

16. Pursuant to federal law establishing accessory and accomplice liability, Planned Parenthood member-affiliates, and employees, staff, servants, officers, or agents of member-affiliates that assist in the performance of abortions or supervise abortions, and/or medical residents and their faculty supervisors that are training in the provision of abortions at Planned Parenthood member-affiliates, could be prosecuted and/or sued in a civil action under the Act for any abortion performed at a Planned Parenthood member-affiliate and/or on a Planned Parenthood patient that is deemed to violate the Act.

V. THE EFFECTS OF THE ACT

A. Effect on Women's Health

17. Women seek abortions for a variety of deeply personal reasons, including the inability or hardship of raising a child, the fact that the pregnancy results from rape or incest, because continuing the pregnancy

threatens their lives and/or health, or because they are carrying a fetus with congenital anomalies. For all these women, the inability to obtain an abortion due to the Act would be devastating.

18. The effect of the Act on women seeking later abortions would be particularly tragic. Although only about 12% of abortions performed nationwide occur in the second trimester of pregnancy, women seeking these abortions are frequently in difficult life circumstances. For example, women carrying fetuses with serious abnormalities such as anencephaly (absence of a brain) or trisomies 13 and 18 (chromosomal abnormalities that cause multiple disabilities and mental retardation) are forced to seek abortions in the second trimester because the diagnosis of the abnormalities is not possible, or much more difficult, until then. In addition, women may be seeking abortions to avert a risk to their health, which may not have arisen or become apparent until the second trimester.

19. Women face other hurdles that may delay their ability to seek an abortion. For example, a woman may have been unable to raise the funds for the abortion earlier in pregnancy. Many women must travel long distances for an abortion due to the severe shortage of abortion providers. Arranging for an abortion in a distant city may be time-consuming. Many women delay having abortions due to the difficulty in taking time off work and/or arranging for child care. A disproportionate number of women seeking second trimester abortions are teenagers, who do not recognize the signs of pregnancy, or ignore or deny them, or are delayed by lack of funds or reluctance to involve their parents.

20. The sole exception to the Act's ban is ineffective to protect women's life and health. The exception permits a physician to perform a so-called "partial-birth abortion" only when it "is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury." 18 U.S.C. § 1531(a). The flaws in this exception are several. First, the Act fails to allow a banned abortion when the woman's health is endangered by the pregnancy but the physician cannot certify that her life is threatened. For example, the condition of a woman with heart disease or diabetes may deteriorate during a pregnancy to the point where, if the pregnancy is allowed to progress to term, she may suffer permanent cardiac or kidney impairment, yet she might survive. In such circumstances, an abortion may be warranted to save a woman's health, although her life is not at risk. But the Act does not permit a banned procedure in this situation. The Act, therefore, imposes severe criminal penalties on a physician who acts according to his or her best medical judgment.

21. Second, the Act does not permit a banned procedure where, regardless of the woman's health status, in the best medical judgment of the physician, that procedure would be the safest or most medically appropriate for a particular patient. It may, therefore, force women to undergo riskier procedures. It thus fails to protect the health of women seeking abortions.

22. Third, the Act does not even adequately protect women's lives because it may be read as allowing use of a banned procedure only when the so-called "partial-birth abortion" is literally "necessary" to save a woman's life, and thus procedures that are not strictly "necessary," because another—albeit riskier—abortion

procedure (such as hysterotomy or hysterectomy) is available, would be banned.

23. Fourth, the inadequacy of the exception is exacerbated by its failure to provide any mens rea requirement for the finding that a "partial-birth abortion" is "necessary" to save the pregnant woman's life. Given the "is necessary" standard, a physician who relies on his or her best medical judgment that an abortion is necessary for the woman's life may face severe criminal penalties if other physicians disagree about the necessity of the procedure. The lack of a mens rea requirement is likely to chill the provision of lifesaving health care.

24. Even if the Act bans only D&E abortions in which the fetus remains intact or largely intact when it is extracted from the uterus (sometimes referred to as intact D&E or dilation and extraction ["D&X"] abortions), an adequate life and health exception is necessary. This is because such abortions may be the safest for some women in some circumstances.

B. Effect on Women's Access to Abortion and other Medical Services

25. The actions that the Act defines as constituting a "partial-birth abortion" could occur in any D&E abortion, including but not limited to intact D&E abortions, as well as in any induction abortion. (As used in this complaint, the term "D&E" includes "intact D&Es," and the term "intact D&E" is interchangeable with the term "D&X.") This is because:

(a) in all D&E or induction abortions, the person performing the abortion "deliberately and intentionally vaginally delivers a . . . fetus," 18 U.S.C. §

1531(b)(1)(A), and in many instances, the fetus is "living" when that occurs;

(b) in any D&E or induction abortion, the fetus, while still "living," may emerge until "in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother," *id.*;

(c) in many instances—whether the abortion is a D&E or induction procedure—after the fetus has emerged to the point that the Act specifies, the physician may "perform[] an overt act," *id.*, short of completing the delivery, that the physician knows may result in fetal demise, and then will complete the procedure. This "overt act" (regardless of whether the procedure is a D&E or induction abortion) could involve: collapsing the calvarium (fetal skull) to enable it to be brought through the cervical os (opening), cutting the umbilical cord, or disarticulating a piece of the fetus; and

(d) the physician's "purpose," *id.*, in performing any abortion procedure—whether D&E, intact D&E or induction—is not to perform any particular act. Rather, the purpose in any abortion is the same: to complete the delivery as safely and quickly as possible. The "purpose" language therefore does not limit the Act's reach.

26. While not all D&E or induction abortions will proceed in a manner that violates the Act, physicians cannot know or predict in advance which abortions will so proceed. Accordingly, performing any D&E or

induction abortion places doctors at risk of violating the Act.

27. Together, D&E and induction abortions account for more than 95% of previability abortions performed in the second trimester of pregnancy.

28. If neither D&E nor induction abortions were available, the only remaining abortion option for women in the second trimester of pregnancy would be hysterotomy or hysterectomy. Hysterectomy involves making a surgical incision into the uterus to deliver the fetus. Hysterectomy involves surgical removal of the entire uterus. As major abdominal surgery, both hysterotomy and hysterectomy involve many times the risk of either D&E or induction procedures, and must be performed in a hospital. Moreoever, hysterectomy precludes future childbearing. For those reasons, they have been virtually abandoned as methods of abortion.

29. If the Act were to take effect, Plaintiffs would be chilled from providing D&E or induction abortions because of the reasonable fear of criminal prosecution and civil liability under the Act. It therefore imposes an undue burden on women seeking second-trimester abortions.

30. The Act's definition of "partial-birth abortion" fails to give Plaintiffs fair warning as to what conduct is prohibited. In addition, the Act fails to give fair warning as to what conduct is "in or affecting interstate . . . commerce." The Act thus forces physicians to guess—under threat of criminal prosecution and civil liability—whether performing an accepted medical procedure falls within the Act's proscription. Moreover, because of the Act's vagueness, prosecuting attorneys may differ widely as to what conduct they believe is

proscribed by the Act. It thus subjects Plaintiffs to arbitrary and discriminatory prosecution.

31. If the Act is allowed to take effect, access to abortions in the second trimester of pregnancy—with the exception of hysterotomy and hysterectomy—would be severely curtailed in the United States because Plaintiffs and other abortion providers would be chilled from performing D&E and induction abortion procedures in the safest manner because doing so could result in a procedure that is banned by the Act. This would prevent some women from obtaining an abortion altogether; delay some women who decide to go out of the country or to a distant part of this country, to obtain a safe second-trimester abortion, thus increasing the medical risks of the procedure; and force some women to have relatively riskier abortion procedures, increasing the possibility of damage to their lives and health.

32. If the Act were to take effect, it could also chill physicians from providing necessary medical care to women who present at the hospital in the middle of a second trimester miscarriage because the medical assistance provided to complete the miscarriage could violate the terms of the Act.

33. If the Act were to take effect, physicians may be compelled to obtain parental and/or spousal consent to all D&E abortions performed on women under the age of 18 and married women in order to avoid the risk of civil lawsuits by a parent and/or spouse whose daughter/wife had an abortion that the parent and/or spouse contends is a so-called "partial-birth abortion."

VI. INJUNCTIVE RELIEF

34. Plaintiffs have no adequate remedy at law and will suffer irreparable harm for continued violations of their and their patients' constitutional rights if the Act goes into effect.

35. Enforcement of the Act will cause irreparable harm by threatening Plaintiffs with criminal prosecution and civil liability for providing, teaching, participating in, assisting in, or supervising the provision of abortion services in the second trimester of pregnancy, thereby chilling the provision of those services; prevent some patients from receiving abortion services in the second trimester; force some women to obtain medical care that is more dangerous and/or more likely to deprive them of the ability to bear children in the future; delay other women in obtaining abortions, thus increasing the medical risks to their life or health; deprive women of their right to determine the course of their own medical treatment; and compel doctors to abridge patient confidentiality by obtaining parental and/or spousal consent to the abortion in order to avoid potential civil liability.

VII. FIRST CLAIM FOR RELIEF

36. Plaintiffs hereby incorporate by reference Paragraphs 1 through 35 above.

37. By prohibiting health care facilities and physicians, at any stage of pregnancy, from performing so-called "partial-birth abortions" where necessary to preserve the woman's health or where that procedure would be the most medically appropriate for the woman, and by limiting the circumstances under which a physician can perform a so-called "partial-birth abortion" to preserve the woman's life, the Act violates the

right of women to privacy, life, and liberty guaranteed by the Due Process Clause of the Fifth Amendment.

VIII. SECOND CLAIM FOR RELIEF

38. Plaintiffs hereby incorporate by reference Paragraphs 1 through 37 above.

39. By prohibiting health care facilities and physicians from performing so-called "partial-birth abortions," at any time during pregnancy, the Act has the purpose and effect of imposing an undue burden on women's right to choose abortion, in violation of their right to privacy and liberty guaranteed by the Due Process Clause of the Fifth Amendment.

IX. THIRD CLAIM FOR RELIEF

40. Plaintiffs hereby incorporate by reference Paragraphs 1 through 39 above.

41. By depriving women who have already decided to have a pre-viability abortion of the right to have the medically accepted abortion procedure of their choice, and by forcing women to obtain abortion procedures that are medically riskier, more intrusive, and more painful than those banned by the Act, the Act violates the right to bodily integrity guaranteed by the Due Process Clause of the Fifth Amendment.

X. FOURTH CLAIM FOR RELIEF

42. Plaintiffs hereby incorporate by reference Paragraphs 1 through 41 above.

43. By failing to give adequate notice of the procedures it proscribes, and by encouraging arbitrary enforcement, the Act is impermissibly vague, thereby violating the right of Plaintiffs and their employees and

agents to due process, as guaranteed by the Fifth Amendment.

WHEREFORE, Plaintiffs ask this Court:

A. To issue a temporary restraining order, a preliminary injunction, and a permanent injunction restraining Defendant, his employees, agents, and successors from enforcing the challenged Act;

B. To enter judgment declaring the challenged Act to be in violation of the United States Constitution;

C. To grant such other and further relief as this Court should find just and proper, including attorneys' fees and costs.

DATED: November 13, 2003

BINGHAM McCUTCHEON LLP
PLANNED PARENTHOOD
FEDERATION OFAMERICA

By: /s/ BETH H. PARKER
BETH H. PARKER
Attorneys for Plaintiffs
Planned Parenthood
Federation of America, Inc.
and Planned Parenthood
Golden Gate

UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

Trial Date: Mar. 29, 2004
Courtroom: Judge Phyllis J. Hamilton
E-FILING

STIPULATION AND ORDER

The parties hereby stipulate, by and through their attorneys, that the designations and counter-designations of the following deponents, previously identified and provided to the Court, be filed with the Clerk of the Court along with the exhibits attached to the designations:

Rebecca Baergen, M.D.

Alan Baker (APHA)

Joanna Cain, M.D. (ACOG)

Steven L. Clark, M.D.

Marilyn Conners Frederiksen, M.D.

Amos Grunebaum, M.D.
Cassing Hammond, M.D.
Meghan Kissel (AMWA)
Wan Joo Kim
Charles J. Lockwood, M.D.
William Moschella
John Whitelaw, M.D. (CMA)

The parties attach as Exhibit A the page/line designations and counter-designations for Steven L. Clark, M.D., and Charles J. Lockwood, M.D. These were not previously filed with the Court.

DATED: June 4, 2004

BINGHAM McCUTCHEN LLP
PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

By: BETH H. PARKER
BETH H. PARKER
Attorneys for Plaintiffs Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate

DATED: June 4, 2004

DEPARTMENT OF JUSTICE

By: SCOTT SIMPSON
SCOTT SIMPSON
Attorneys of Defendant John Aschroft

IT IS SO ORDERED

PHYLLIS J. HAMILTON

PHYLLIS J. Hamilton
United States District Judge

Date: 6/8/04

BINGHAM McCUTCHEN

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March 24, 2004

Via Facsimile

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Re: PPFA v. Aschroft

Dear Mark and Scott:

Below are the designations for Dr. Clark we are providing to the Court today:

Steven Clark, M.D., Counter Designations

7:12-19
12:2-14
13:3-19
15:8-12
18:23-19:5
21:4-5
21:25-22:4, 10-16
24:3-10
25:2-13
30:3-9
35:9-24
36:11-14
37:14-16, 37 -38:3, 9-14
40:5-24
41:3-42-1
43:20-44:2
49:12-22
52:22-53:1, 11-12
54:19-23
55:8-9, 14-16

59:22-60:2
61:5-9, 14-20
87:5-21
95:18-21
96:7-12
97:8-11

98:6-10
103:13-25
112:3-6
131:16-132:7
144:11-14
144:22-145:1
145:14-146:15
147:4-23
168:13-18
173:12-174:11
178:15-179:21
190:20-191:1

Sincerely,

/s/ BETH H. PARKER
BETH H. PARKER

cc: Eve Gartner

Defendant's Designations: Steven L. Clark, M.D.

1:14-19
10:23-12:1
12:15-13:2
13:20-15:7
16:11-18:22
19:7-20
22:17-24:2
24:11-25:1
28:1-23
29:21-30:2 (Beginning with "Do you use...")
31:13-33:1
33:13-34:14
34:16-35:2
35:16-37:13
39:12-25
44:8-25
45:20-46:14
47:8-14
47:16-48:6
48:8-49:18
52:6-21
54:9-18
56:7-57:1
58:2-16
61:21-23
62:19-63:18
69:24-70:9
70:12-13
72:10-15
72:18-74:11
75:21-76:6
87:22-88:12
88:15-90:4

100:18-103:12
105:23-106:18
106:21-25
107:2-17
108:16-111:4
111:7-112:6
112:9-25
113:3-8
113:11-115:18
115:21-116:21
116:23-117:15
117:18-118:3
118:7-119:19
120:21-121:5
121:8-10
121:12-17
121:19-22
123:11-12
123:15-124:7
124:9-125:8
125:21-126:19
127:17-20
127:22-128:7
128:9-129:11
129:13-130:1
130:3-21
130:23-131:11
131:13-15
133:3-6
133:8-134:12
134:14-21
135:4-10
135:12-23
136:7-9
136:11-137:1

137:3-20
137:22-138:7
138:9-139:16
139:18-21
142:16-143:5
145:2-13
148:13-149:2
149:4-19
149:21-150:2
150:4-152:9
152:11-154:3
154:5-14
154:16-21
154:23-155:15
155:17-19
158:12-159:1
161:11-162:2
162:14-16
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167:23-168:12
169:6-13
174:12-15
174:17-20
174:22-176:15
181:3-5
181:7-13
182:22-23
182:25-183:8
183:10-184:8
184:10-187:8
187:10-190:19

Defendant's Designations: Charles J. Lockwood, M.D.

4:22-25
6:4-9
7:10-13
26:24-29:23
72:17-76:6
79:18-80:22
81:6-83:22
86:16-88:3
88:11-89-23
95:18-96:15
101:3-9
101:24-103:13
106:2-107:2
109:16-111:5
111:21-112:10
112:19-113:16
115:22-116:7
116:22-117:18
118:14-120:15
120:24-121:6
129:12-131:8
136:22-137:4
138:6-139:4
148:19-149:19
156:21-157:23
160:5-171:8
172:8-10
175:11-176:7
189:14-190:9
193:13-199:13
200:14-202:23
203:12-205:23